

Navy Medicine

July-August 2006



NAVY MEDICINE

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Cover: On 17 May, the aircraft carrier USS *Oriskany* (CVA-34) slipped beneath the surface of the Gulf of Mexico to begin a new life as an artificial reef. An incident during the vessel's Vietnam War days appears on p. 29. Photo courtesy of www.flickr.com.

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A diver examines *Oriskany* from a new perspective. Photo www.myfwc.com

The recently founded Society for the History of Navy Medicine announces its first Annual Meeting and Paper Session, to be held during the annual meeting of the American Association for the History of Medicine in Montreal, 3 - 6 May 2007. The Society solicits papers concerning any aspect of the history of medicine in the maritime environment (including above and below the surface of water). Graduate student work and other "works-in-progress" are particularly encouraged. Electronic submission of a 200-250 word abstract is particularly welcomed, though faxed or mailed submissions will be accepted. For more information please contact Mr. Sobocinski at absobocinski@us.med.navy.mil

Navy Medicine Family,

Adverse outcomes occur during medical care. Everyone who works in the field of medicine knows this. In late 1999, the subject was the focus of a detailed report by the Quality of Health Care in America Committee of the Institute of Medicine: "To Err is Human: Building a Safer Health System."

As many of our beneficiaries read recent news stories focused on adverse medical outcomes and malpractice, they might be asking "To what standards does Navy medicine aspire and how well are we achieving them?"

Ask all the women who are seen at the NNMCMaternal Infant Care Center. The center received the "BEST TEAM" award from Nursing magazine "Advance for Nurses" which recognized the staff for their ability to adapt to change while giving top rate care to mothers and babies. The center sees about 180 patients a month and is considered the military's top high-risk pregnancy center in the Washington, DC, area.

Ask the Marine who was in some of the bloodiest battles in Fallujah, Iraq and suffered severe facial wounds and got his smile back in 6 months because of the work of our skilled surgeons.

Ask the injured Navy corpsman who lost a limb during the early days of the war when he attempted to rescue a wounded Marine from a minefield. After a long recovery—during which he rendered care to other injured veterans at Bethesda—he has completed his rehabilitation.

Ask the beneficiaries who receive their care at Naval Hospital Pensacola, which received top honors from the Department of Defense for patient satisfaction. In 2005, the hospital was recognized for the excellent customer service provided to all of their patients—uniformed service members, retirees, and their families.

Ask the Marines, sailors, soldiers, and airmen who receive medical and mental health services from more than 60 doctors, nurses, and corpsmen and medics from the Navy and Army at the Expeditionary Medical Facility in Kuwait. The facility is staffed primarily by Navy personnel from Naval Medical Center San Diego, Naval Hospital Camp Pendleton, Naval Hospital Bremerton, and Naval Hospital Oak Harbor.

Ask any of our beneficiaries. In 2005, Navy medicine conducted over nine million medical appointments and nearly two million dental appointments, recorded nearly 90,000 admissions, delivered nearly 20,000 babies, and filled nearly 15 million outpatient prescriptions.

Ask me. I am always ready to tell the success stories of Navy medicine and I know you are as eager as I am to spread our good news.

However, adverse outcomes and, yes, errors do happen and they are costly in many ways. The physical and psychological impact on the patients and families, as well as the potential loss of the trust by our beneficiaries, are significant but difficult to quantify. We must work to earn their trust every day by offering healing and comfort and by ensuring our healthcare providers embrace the highest standards of training, practice, and professional conduct. Navy medicine honors the trust our beneficiaries place in us and we, in turn, provide world class medical services.

Like the civilian healthcare system, Navy medicine continually monitors the professional performance of all our healthcare providers. We also examine the current procedures of all hospitals and clinics across our enterprise to ensure no system issues exist that might adversely affect the healthcare provided.

Every privileged military physician, dentist, nurse, and allied health professional has a current unrestricted state license. Licensure represents a rigorous examination process designed to assess a provider's ability to apply knowledge, concepts, and principles important in health and disease management as the basis for effective patient care.

Navy medicine's graduate education programs are among the best in the country. We have 43 residency programs, three transitional year programs, and 14 fellowship graduate programs. In addition, more than



95 percent of our physicians pass their board certification on the first attempt, well above the national average of 85 percent.

Navy medicine maintains a single enterprise-wide standard for credential review that meets or exceeds the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for all healthcare professionals. JCAHO is the premier accreditation organization for healthcare facilities in the U.S. Credentialing, the process of obtaining, verifying, and assessing the qualifications of a healthcare provider, is based on four core criteria: current licensure; relevant education, training and experience; current clinical competence; and the ability to perform requested privileges. Privileges must be requested and granted by the facility in which the provider wishes to practice every 2 years or earlier if a provider transfers to another duty station.

When an adverse patient outcome occurs, it is reviewed initially by the treating facility's Quality Assurance office. The preliminary report is immediately shared with the involved departments, clinics, or wards. The purpose of this review is to gather all information; to determine why the outcome occurred and whether the standard of care was met; and to identify any further action required. In all cases where further action is warranted, the case is forwarded to the Executive Committee of the Medical Staff (ECOMS) for review and comment. Actions recommended to the commanding officer may include additional reviews of individual provider performance or similar cases to evaluate trends; counseling, training and education; or more detailed investigation such as a formal root cause analysis. If the unexpected patient outcome involves death or serious injury, a determination is made whether it is a reviewable sentinel event. If so, a verbal report is made to the JCAHO and followed by a written report. The treating facility is then required to submit a final written report of the results of actions taken to close the case. All quality assurance reviews are privileged and protected from disclosure except as authorized under 10 USC § 1102.

While there is no established benchmark or standard to measure malpractice rates, it is our goal to eliminate negative outcomes through our quality assurance and reporting processes. Department of Justice data show that 2.4 claims annually per 100 providers is the civilian average and that Navy medicine's average is significantly less. Not satisfied with any adverse outcomes, we will continue to drive the incidence as low as humanly possible.

In aggregate, our processes for assuring quality are designed to provide the highest quality of care, prevent adverse outcomes, rapidly and thoroughly treat those who suffer an untoward event, and systematically address and resolve what we identify as root causes of variation.

These are just some of the tools Navy medicine uses to ensure the care being provided at our treatment facilities meets the highest standards. I deeply regret when adverse outcomes touch any of our patients. Yet I know we provide the support they and their families need to get through difficult times. The practice of medicine holds inherent risk and I understand how important reliable, consistent, and safe patient care is to our beneficiaries. Navy medicine is absolutely committed to the sailors and Marines serving our country, to their families who look to us for care, and to the veterans who have devoted their lives serving our nation. It is our duty and privilege to provide these heroes the highest quality care at our military treatment facilities around the globe and to use the tools of modern medicine and the healthcare system to unceasingly improve the quality of care we provide. ⚓

Best regards,

*VADM Don Arthur, MC, USN
Surgeon General of the Navy*

NOTICE TO ALL ACTIVE DUTY AND RETIRED NAVY PERSONNEL

Sailors Warned Of VA Data Compromise

The Department of Veterans Affairs (VA) announced 3 June that active-duty sailors may be affected by the theft in May of military personnel data.

According to the VA, a duplicate database with data files was stolen from a VA employee's home 3 May. While the VA has received no reports that the stolen data has been used for fraudulent purposes, they are asking all veterans to be extra vigilant and to carefully monitor bank statements, credit card statements, and any statements relating to recent financial transactions.

Several resources are available for people to go to for more information. The Department of Veterans Affairs has set up a special website (www.firstgov.gov) and a toll-free telephone number (800-FED-INFO or 800-333-4636) that feature up-to-date news and information on the data compromise. The site offers tips on how to check credit reports, guard against identity theft, and whom to call if an individual believes any fraudulent activity is occurring using his or her personal information.

The Navy and Department of Defense are working closely with the VA to determine how many sailors and other service members may be affected by the compromise of records. Sailors whose information has been compromised will be notified by a letter from the VA and the Navy so they can take the appropriate steps.

Tips on how to watch for suspicious activity include the following:

Closely monitor your bank and credit card statements for fraudulent transactions. Monitoring accounts online is the best way to detect fraud early.

Place a 90-day fraud alert on your credit report, which tells creditors to contact you before opening any new accounts or making any changes to your existing accounts. This action may cause some delays if you are trying to obtain new credit.

It is only necessary to contact one of three companies to place an alert. That company is then required to contact the other two.

The three companies are Equifax (800-525-6285, www.equifax.com), Experian (888-397-3742, www.experian.com), and TransUnion (800-680-7289, www.transunion.com).

Once the fraud alert has been posted, you are entitled to free copies of your credit reports. Review these reports for inquiries from companies you haven't contacted or accounts you didn't open. The alert can be renewed after 90 days.

Sailors are advised to take the following steps if they discover fraudulent accounts or transactions:

Contact the financial institution to close the fraudulent account(s) that have been tampered with.

File a report with the local police department.

File a complaint with the Federal Trade Commission by phone at 877-438-4338, online at www.consumer.gov/idtheft, or by mailing a letter to Identity Theft Clearinghouse, Federal Trade Commission, 600 Pennsylvania Avenue NW, Washington, DC 20580.

Other websites with more information on how to guard against identity theft include:

www.privacy.ca.gov/sheets/cis3_english.htm

www.co.boulder.co.us/da/consumer/idtheft.htm

Chief of Naval Personnel Public Affairs Press Release

Change of Command at EMF Kuwait, Camp Pendleton Detachment

During a 29 April formal military Change of Command ceremony in the Kuwait desert, CAPT C. Forrest Faison, MC, assumed command of U.S. Military Hospital Kuwait from CAPT Catherine A. Wilson, NC.

During her remarks, CAPT Wilson reflected on her 5½ months in command, “I could not have been part of a better team. This team always did the right thing even when nobody was looking.” During her tenure, the Expeditionary Medical Facility Kuwait (EMFK) Camp Pendleton Detachment and its nine outlying clinics averaged 17,500 monthly patient encounters. Wilson’s deployment as commanding officer of the EMFK was cut short after she was recently selected to command Naval Hospital Bremerton, WA.

COL James Rice, commander of the First Medical Brigade, said of CAPT Wilson, “The families, patients, and sailors of the Naval Hospital Bremerton do not yet know what a great commander they are getting but they will soon find out.” Rice was Wilson’s immediate superior in command as the EMFK reports to the First Medical Brigade.

Keynote speaker, LGEN R. Steven Whitcomb, commanding general of the Coalition Forces Land Component Command, noted in his remarks, “Our ability to save Marines, soldiers, airmen, and sailors injured in combat is phenomenal. It’s a capability not just because of the technology, it’s a capability through the hearts and minds and fingers of our medical personnel that are so skilled in what they do.”

“The fact that you can return 65 percent of the troops that come down to this facility back to the fight, as a commander, is significant to me. CAPT Wilson provided the leadership, the direction, the vision, and guidance for her watch and you all (EMFK staff) executed. I commend you for this execution and, CAPT Wilson, I commend you for your leadership of this team to accomplish your vision and make your foxhole better than when you arrived. And that’s the best that we can hope for as leaders and commanders.”

In his remarks, CAPT Faison addressing the EMFK staff said, “Each of you represents America’s promise to its mothers and fathers that we will do all in our power to return home safely the sons and daughters they’ve entrusted to us. Further, it’s a promise we make not only to America’s mothers and fathers but to those of our Coalition partners as well. That’s a promise we’ll continue to keep on my watch. We




LGEN Whitcomb and COL Rice look on as CAPT Wilson transfers command to CAPT Faison. Photo by HM3 Debra Honoway

cannot keep that promise alone. It’s a team effort, a team of Army, Navy, and Air Force working as one. In the end, it doesn’t matter what uniform any of us wear since we’re not just Army, or Navy, or Air Force—we’re Americans—and we’re here keeping a promise on behalf of a grateful nation. We cannot succeed in keeping that promise unless we succeed together—one team, one fight, one promise entrusted to our care.”

Faison’s previous assignment was Deputy Commander, Naval Medical Center Portsmouth, VA, leading a staff of 6,000 delivering care in Navy medicine’s largest medical facility.

The EMFK, Camp Pendleton Detachment is the third year-long Navy medicine detachment to staff the U.S. Military Hospital Kuwait and its nine outlying clinics in Kuwait and Qatar. The EMFK is staffed by Navy personnel from 26 medical activities around the world.

The U.S. Military Hospital Kuwait is a level three medical facility that provides outpatient, inpatient, emergency care, and specialty services such as cardiology, pulmonology, critical care, internal medicine, general surgery, optometry, orthopedics, gynecology, laboratory, pharmacy, radiology, mental health, dental, and physical therapy. More than 350 doctors, nurses, corpsmen, and support staff carry out the EMFK mission of providing healthcare to Department of Defense personnel and Coalition forces stationed in, or transiting through the U.S. Army Forces Central Command area of responsibility to include Kuwait, Qatar, Afghanistan, Iraq, and Fleet Forces. 

—Story by CAPT Lee L. Cornforth, MSC, USN.

BUMED Hosts Ceremony Honoring the 98th Birthday of Navy Nurse Corps

The Navy Nurse Corps celebrated 98 years of service 12 May with a cake cutting ceremony at the Bureau of Medicine and Surgery. The official birth date of the Nurse Corps is 13 May 1908.

With a force of 5,000 active duty and Reserve nurses, the Nurse Corps is prepared to employ their medical skills in support of their fellow Marines and sailors stateside and abroad.

“This is what has held our nurses together for the past 98 years, the nurse’s ability to adapt to the environment in which they are placed because of their strength, their commitment, and their compassion,” said RDML Christine Bruzek-Kohler, Director, Navy Nurse Corps. “Navy nurses are one member of a very large and important healthcare team. The value that we provide is unique to our profession, but it is not in and of itself the only thing that takes care of patients. Navy nurses are partners on the greatest healthcare team in the world.”

Navy medicine’s operational, conventional, and humanitarian missions benefit from the Nurse Corps’ combination of educational and training programs, and the exchange of their medical expertise across the federal, state, local, and international arenas. To meet the challenges of today’s world, the role of the Navy nurse continues to evolve into a greater perspective which crosses the joint service and interagency world at all levels.



RDML Bruzek-Kohler, Director, Navy Nurse Corps, and ENS Jannie Brice make the first cut in the birthday cake. Photo by Christine Mahoney

Intern nurses from the National Naval Medical Center read birthday letters from VADM Donald Arthur, MC, Navy Surgeon General; RDML Adam Robinson, MC, Chief, Navy Medical Corps; RDML Brian Brannman, MSC, Director, Medical Service Corps; RDML Christine Bruzek-Kohler, Director, Navy Nurse Corps; and FORCM Robert Elliott (FMF/SS/SW), Navy Medicine Force Master Chief.

At the end of the ceremony, RDML Bruzek-Kohler and ENS Jannie Brice, the youngest member of the Nurse Corps, cut the first piece of birthday cake. Nurse Corps members and guests were invited to enjoy the cake and refreshments, and congratulate members on their 98th birthday.

A nurse’s job is never routine, always demanding, with constant challenges and rewards. Service members, family members, and veterans need not worry when it comes to receiving the best medical care they deserve because that is what Navy nurses do: provide the best medical care, anytime, anywhere. ✍

Story by Christine A. Mahoney, Public Affairs, Bureau of Medicine and Surgery, Washington, DC.

Veterans Affairs’ Medical Facilities Welcome Women Veterans

There was a time when women veterans didn’t feel welcome at Veterans Affairs Department medical facilities, but the causes of such feelings have changed dramatically over the last few years, VA’s top advocate for women’s health said. “We’re seeing a dramatic increase in the number of women veterans turning to VA for healthcare,” Carole L. Turner, Veterans Affairs’ national director for the women veterans health program, said. “And the satisfaction they’re expressing about the healthcare they receive at VA is improving tremendously.”

Turner said VA has a full continuum of comprehensive medical services, including health promotion and disease prevention and primary care. There is also women’s gender-specific healthcare, such as hormone replacement therapy, breast and gynecological care, and maternity and limited infertility treatments. There is also substance-abuse treatment, mental health, rehabilitation, and long-term care.

“If a specialty isn’t available in-house, VA will contract out with providers in the community,” said Turner, a former Air Force nurse who has more than 20 years of VA experience.



Carole L. Turner, Director, Women Veterans Health Program

Military sexual trauma treatment also is available, including counseling and treatment for any emotional or physical condition experienced as a result of sexual trauma experienced while on active duty.

Turner said women often seek treatment for “the same kind of health conditions that men experience—diabetes, heart disease, orthopedics care, dental care.” However, she added, women veterans also require certain unique healthcare services, such as maternity care.

There also are differences in the types of assistance service women seek from the VA. “Women who are homeless generally come with families or children,” Turner said. VA has pilot programs for homeless women veterans with and without children at 11 medical facilities around the country.

VA also works to educate women on ways their health issues differ from men’s—for instance, how heart disease manifests itself differently in women than in men. She said VA is working with healthcare providers to ensure they’re aware of and looking for signs and symptoms in women that they wouldn’t ordinarily think are attributable to heart disease. Turner emphasized that “all VA facilities aren’t created equal. Some are very urban, highly affiliated academic teaching facilities, and some are very rural, kind of like a general-practice arrangement,” she said.

But no matter what type of facility women visit, they’re going to get quality breast care, either within the VA center or outsourced, she said. Studies indicate that newly diagnosed and treated breast cancer patients often suffer from such quality of life problems as insomnia, weight gain, chronic fatigue, depression, and anxiety. “VA is very well equipped to help the social ramifications of disease,” Turner said. “The VA offers one-stop care for the majority of biological, psychological, and social healthcare problems women might be experiencing,” Turner said.

VA also has published privacy standards, particularly for treating women. Gone are the days when women didn’t feel welcome at VA hospitals and voiced concerns about the lack of privacy, Turner said. “We also have waiting areas that are like subunits so women can wait separate and apart from men,” she said. “The environment has been designed so women can bring their children, so they know that they’re safe and secure.”

Turner attributes much of VA’s success in treating women veterans to women program managers who are advocates at every medical center. “They’re there to help women veterans navigate the system,” she said. “They try to ensure that the types of issues and concerns women might have about the environment or the care they receive are being addressed by staff and facility leaders who are sensitive to those needs.”

—Story by Rudi Williams, American Forces Press Service.

NUMI Graduates Seven IDCs

Naval Undersea Medical Institute graduated Independent Duty Corpsman Class 218 in a ceremony 10 March at the Submarine Force Library and Museum.

For the IDCs (independent duty corpsmen), the ceremony marked the end of an arduous 15-month battle through one of the Navy’s most challenging courses. Of the 16 corpsmen who eventually classed up, only seven graduated.

According to class counselor HMC(SS/SW/FMF) Raymond Meyers, this year’s group was the best one he’s seen. “They all did very well and came together as a team,” he said. “Each one brought different strengths to the table and helped each other out.”

Although there are many avenues for corpsmen to take, such as Fleet Marine Force or SEALs, HM1(SS) Stuart Baird chose the path of submarine IDC because of its challenges. “The IDC [course] is one of the most challenging courses out there,” said Baird. “Also, I chose this career path because it’s one of the few where I can truly work independent of a medical officer.”

Baird said he knew the course would be challenging but he was surprised at how much he underestimated the amount of material he and his classmates absorbed.

“There is so much information to learn,” said Baird. “They actually cram about 2 ½ years of information into 56 weeks. It starts to wear on you at the end but I had a good time. Now I’m ready to go on to my next tour.”

While everyone agreed the IDC course was near the top of the list of their most challenging accomplishments, they noted there were certain factors that played into their success. For HM1(SU/FMF) Adam Goulas, that meant classing up with people who took the challenge seriously.

“It’s not that hard to get into the school but it’s definitely hard staying in. As a corpsman there is no harder school,” said Goulas. “It helps going through the school with highly intelligent and motivated people. Everyone who is here wants to be here, and there is a real camaraderie here because of that.”

“The attrition rate is astronomical here, well above 50 percent,” added HM1(SU) Dennis Green. “We started with 16 people, we gained two, and we’re graduating seven. The amount of pressure you get from this school and the stress level you deal with going through this school can be very burdensome.”

With 140 written exams, five oral boards, a week-long practical scenario, and 3 months spent going to various clinics, including Yale/New Haven Hospital’s Trauma Center and working on the frontlines, it’s easy to see how these students might grow tired.




"And we're studying at home when we're not at school," said Green. He also said that he and his classmates were surprised once the curriculum was outlined and they realized that learning about medicine would really only take up a small part of their time.

"Prior to coming here, I didn't think we would take on as much administrative work, meaning learning to develop administrative skills," said Green. "But, one thing I learned through the school was time management. You can't have anything planned out in this job. Certain situations will arise that will throw your scheduling off and with that, you have to be flexible, multitasking and prioritizing certain situations ahead of others."

"Most of us thought medicine would be the biggest part of the school," added Goulas. "But in reality, it's about 80 percent radiation health and 20 percent medicine. But in the fleet, medicine will take up 90 percent of our time. So really, we've just spent 80 percent of our time learning how to do 10 percent of our job."

Class 218 is gone now, but their class counselor will stay behind for a little and see what Class 219 brings through the door. Meyers said the IDC course contributes something that most other schools do not, yet it's something from which all Americans benefit.

"This course provides the single medical support for all active submarines. Their students come through the school and leave to directly support the global war on terrorism," said Meyers. "Every IDC immediately goes to an operational unit and we are one of the few medical corps schools that directly support these efforts." 

—Story by JO3 Steven Feller, NUMI Public Affairs.

Navy Medicine Senior Leaders' Orientation Program

From its historic hilltop home in Washington, DC, the Bureau of Medicine and Surgery (BUMED) administers and outlines the policy of the Navy Medical Department. And to know and understand what Navy medicine is, one must know its echelons and how they operate; one must know BUMED.

For about 10 years, BUMED has met this need through a unique 2½-day Navy Medicine Senior Leaders' Orientation Program primarily for prospective COs, and XO's, but also offered and available to Senior Enlisted Leaders, Specialty Leaders, and senior BUMED staff. For the last 4 years, the program has been managed by Process Management & Integration's (PM&I) Mrs. Jean Faul. "Nine times out of ten PCO/PXO and Specialty Leaders come to the Bureau of Medicine and Surgery before they start at their new duty stations," Faul explains. "The program is offered to all new PCO/PXOs up to 6 months into their new duty station."



CAPT Michael Adams, MSC, CO of the BUMED 106th Reserve Unit, reviews his orientation schedule with Mrs. Faul.

Once the Bureau of Personnel (BU-PERS) announces prospective duty stations for PCO/PXO's, Mrs. Faul generates a letter inviting them to participate in this program. Mrs. Faul adds, "This letter is where the majority of personnel hear

about the program. However, 'word of mouth' has also been very effective in attracting participants."

After the Senior Leader confirms his/her interest in visiting, Mrs. Faul sends a "pick list" of BUMED codes and arranges the date of their orientation. Their selections form the basis of an individually customized orientation schedule. Options include: OPNAV—Medical Resource Plans and Policy; BUMED codes—Human Resources (including Corps Chiefs); Operations (including Business Planning, Homeland Security, Risk Management, Occupational Health and Safety), Future Plans and Strategies, Resource Management; BUMED Special Assistants (including Medical Inspector General, JAG, Legislative and Public Affairs and Navy Medicine Historian), etc.

"Program evaluations tell us the participants are extremely happy with the program and the time invested in their visits here," Mrs. Faul points out. "These senior leaders get a fine overview of what goes on in Navy medicine at the policy level—and there is a lot that goes on. In addition, the program enables the participants to develop important contacts as well as putting faces and names together."

To PCO CAPT William W. Hanes, DC, USN, who attended this orientation in April 2006, the program has immense value. "It is great to be back and have the opportunity to not only interface with the folks that you deal with in Navy medicine but also to take a look at the organization structure from the '40,000 foot view,' if you will. As I told several of the people I have met since I've been here, the historic buildings are the same, but very little else has remained the same since I was last here 15 years ago. A tremendous amount of change has occurred, specifically within the last 2 to 3 years. This program provides a great opportunity, prior to going out in the field and working with the troops, to be able to identify key points of contact. You sit across the table and develop a better understanding of what they do and what their mission is so it will help you do a better job out in the field."

To learn more about the Senior Leader Orientation program, and/or to arrange a visit to BUMED, please contact Mrs. Jean Faul at JCFaul@us.med.navy.mil or 202-762-3838. 

CPG 3 Promotes Health Awareness

Members of Amphibious Group 3 (CPG 3) took time out of their busy schedules 7 April to participate in a health awareness program designed to help sailors maintain healthier life styles.

CPG 3's medical department brought in health professionals to promote self-health awareness, informing sailors on daily calorie intake, healthy food choices, keeping cholesterol and blood pressure under control, and other preventive care issues.

"We want to get people medically ready and screen them before problems occur," said the health awareness program's coordinator HMCS(SW) Brenda E. Quarles.

"The majority of service members don't get the proper care, simply because they think they are in great shape or lack the symptoms," added Quarles. "We had healthcare professionals come to CPG 3 to eliminate myths. From heart diseases to nutritional awareness, the staff received a great deal of helpful information. This was important because this helps to enhance their knowledge and makes the service members more aware of their health."

CPG 3's initiative is part of a decision by the Navy in 2005 to replace the 5-year physical exam. Now, service members will be screened yearly, increasing the likelihood of diagnosing and treating health problems early to maintain a stronger naval force. Overall, this leads to increased readiness and greater worldwide deployability.

"The new program was implemented 16 February and must be completed Navy-wide by August. Once the initial phases of the program have been completed, sailors will return to medical each year during their birth month recall to have another health assessment," said CPG 3's deputy surgeon LCDR Michael A. Nace. "This was definitely the perfect opportunity for CPG 3's medical department to incorporate both the health awareness program and the preventive health assessment."

CPG 3's medical staff plans to go beyond the basic requirement and hold the health awareness program bi-annually before physical fitness assessments (PFA).

"With the PFA approaching, the health awareness program provided me with useful information," said YN2(SW/AW) Ramon L. Dejesus. "They gave me training on not only how to plan a proper diet, but also on how to achieve personal goals."

Nace refers to the combination of these health awareness programs as "one-stop shopping."

"It is easy," said Nace. "You get them educated and you also get them checked. We are able to get a lot of medical history and information updated."


"It also allows us to make sure the staff is ready for deployment, especially now that everybody is considered for

individual augments (IA). We want to make sure that all the records are updated in the case a detailer calls the service member to be an IA someplace. That way, everything is updated and we are not surprised by it."

Nace added that he has seen the positive affects of similar programs in getting sailors proactively involved in their healthcare and maintaining a culture of fitness.

"From my experience, I see that after a medical screening program, people come to medical more often, either to get their cholesterol screening or to get their blood pressure checked," said Nace. "It is all positive stuff. We have the chance to evaluate folks, get them on medications, diet programs, or anything that will make improvements in their lives and in their health down the road."

Quarles emphasized that this proactive approach is critical for every sailor. She specifically recommended that every sailor take charge of their health by getting "cholesterol screened, blood pressure checked, exercising regularly, and eating healthy."

It is also important for sailors to consult a doctor before changing or starting a new exercise routine. But most of all, added Quarles, you have to "take advantage of the great and free medical benefits that the Navy provides to you." 

—Story by DM(SW)2 Roosevelt Ulloa, *Amphibious Group 3 Public Affairs, San Diego, CA.*

Historic MEDCAP Provides Care to Korengal

Defying estimates of a low turnout, more than 6,300 patients were treated during the course of an historic 6-day medical civic assistance program conducted by the Afghan National Army and Coalition Forces in Kunar Province's Korengal Valley recently.

The MEDCAP was the first ever conducted in the Korengal Valley, long regarded as a sanctuary for enemy fighters before Operation Mountain Lion established a permanent military presence and provided security for the region. That distinction was not lost on the medical staff, comprised of Afghans and Americans, who provided care at a transformed lumber yard established as a Coalition outpost by the Marines of Task Force Lava only days earlier.

"Bringing peace and medication, taking care of the elders and all of the people, that's the most important thing," said Dr. Nazirullah Rahimi, brigade surgeon for 3rd Brigade, 201st ANA Corps. "The people here are poor and don't have access to healthcare," added the doctor, a graduate of the Medical University of Kabul.

Overseeing the MEDCAP alongside Rahimi was LCOL Edward Michaud, director of the Cooperative Medical Assistance team, Combined Joint Task Force-76. Michaud said the true success story of this phase of the operation was Af-

ghans providing care for their fellow countrymen. "It's very important, and absolutely, the people notice the fact that their soldiers are providing security, their medics are providing triage and helping with the treatment of children, and their physicians are seeing patients," said Michaud. "Ours are there helping and present, but what they perceive is important."

Michaud said the success of the MEDCAP also impacts the Afghans working within it, as they prove their legitimacy in the eyes of the people.

ANA medic Noorula said he felt "very good" about being a part of the first such program in the region. Noorula, who spent much of the 6 days administering medicine to children, said he enjoys working as a medic and hopes to continue in the medical field.

"The most important thing the people of this region need is the prevention part, like de-worming," he said. "Besides that, most of the people have stomach pain because of digestive problems." The de-worming station, where children were first sent when they arrived at the MEDCAP, served as an example of basic preventative medicine in action. Worms are endemic in this part of the world, and if not treated, can result in further health problems, according to LCDR Tom Davie, MSC, from the Bureau of Medicine and Surgery. As a reward for taking medication, the children received candy and vitamins.

Adult patients, who went first to the triage station while the children received de-worming medication, also attended hygiene instruction. They each received a kit containing basic hygiene implements. Following the class, those who needed a physician consultation could see a doctor for evaluation. "We enjoy getting medical aid out to people who usually aren't able to get it," said HM2 Stephanie Baldonado, assigned to the cooperative medical assistance team deployed from Camp Pendleton, CA.

Other Coalition medical staff members shared a similar outlook, reflecting that the program is as much about building trust as it is about providing immediate care. "It's not so much medicine as it is prevention," said CDR Sandra Hearn, CMA team member. "I think what we're doing here is making a big difference in having the villagers feel that we are friendly, that we can help them in building schools and roads and other projects, and if we continue to teach the Afghan medical providers to care for them, to take care of hygiene and sanitation, that will improve their health overall."

Afghans who attended the MEDCAP were entitled to receive humanitarian assistance before leaving the outpost known simply as "the lumber yard." Between towering stacks of timber, they passed ANA soldiers, Marines, and U.S. Army soldiers directing them to the distribution point. Items given out included blankets, tarps, metal stoves, grain, beans, rice, cooking oil, tea, sugar, and backpacks for children. "It gives the elders and villagers a level of trust and confidence in their military, to receive aid directly from them," said



An Afghan child holds tight to the humanitarian assistance she received as part of the 6-day MEDCAP operation. Photo by CAPT Dan Huvane, USMC

MAJ Dennis Edwards, civil affairs officer for 1st Battalion, 3rd Marine Regiment. "The thing that was really significant about this MEDCAP, and its associated humanitarian aid distribution, is that it was completely run by the ANA."

It will be the ability of Afghan medical professionals, both military and civilian, to care for the people that will determine success in improving the region's healthcare, Michaud said. "The group we're working with now has run MEDCAPs on their own," Michaud said. "We've worked with this group before in Nangarhar Province and they're getting pretty good at this."

Their level of care is still not quite with what we do but they're definitely improving, he said.

"If we can provide a clinic here, the people will be grateful," added Rahimi, echoing a familiar theme. "Prevention, especially with digestive system problems, is the biggest need of the people here."

The initial effort to provide medical care to a previously isolated region has resulted in such a grateful response, according to Michaud. "We have lots of patients, particularly the elders, women and children, who tell us they are praying for us, and have even been bringing food to us," said Michaud. "I would say it's had a very positive impact on the people, based on what we've seen." ✍

—Story by CAPT Dan Huvane, Task Force Spartan Public Affairs.

Comfort Completes International Medical Exercise

USNS *Comfort* (T AH 20) returned to her homeport in Baltimore harbor 14 May after completing an extended international medical exercise and routine inspections. “The purpose of this mission is to better prepare our sailors and international allies for any event that may constitute the deployment of this ship,” said CAPT Albert Shimkus, NC, Medical Treatment Facility commander.

Comfort sailed to Halifax, Nova Scotia, where U.S. Navy and Public Health Service personnel teamed up with Canadian forces, the British Royal Navy, and a representative from the Japanese Navy to hold an international medical mass casualty drill. Working side-by-side, international allies assessed simulated patients, rendered care, and practiced saving lives.

“It’s important to build bonds between the multinational service,” said British Royal Navy Petty Officer Naval Nurse Lisa Harrison. “At the end of the day, we’re all trying to accomplish the same goal, which is to provide the best medical care possible in each situation.”

“I am pleased with the success of this exercise,” Shimkus said. “Our goal was to build a cohesive international crew and we accomplished that. The bonds formed during this exercise will last forever.”

The mission of this platform is growing to not only include supporting combat operations, but to support both humanitarian as well as disaster relief operations,” he added. “It’s vital that we learn to work with all of our partners because it’s highly likely they will be embarked with us in the future.”

After departing Halifax, *Comfort* made a short port stop in Boston then sailed to Norfolk, VA, where she underwent mandated substance material and readiness testing. “The testing provides verification that equipment is working properly under actual operating parameters, such as full electrical load and design pressures with the ship working in a seaway,” said Richard Cicchetti, the ship’s master. “These are conditions that a pier side dock trial cannot fully replicate. Additionally, many components of the ship are being tested under worst case scenario parameters, such as generator feedback, emergency startup from dead ship conditions, as well as equipment shutdowns.”

David Lieberman, the ship’s second mate, said extra work was put in to prepare for the testing, but the ship is always ready to deploy in a moment’s notice. “The engineers and the rest of the crew are always working hard to



USNS *Comfort* (T AH 20)



VADM Donald Arthur, Surgeon General of the Navy, addresses the crew of *Comfort* during her stop in Boston, MA. Photo by JO3 Heather Weaver

keep the ship operational,” Lieberman said. “This national asset will be fully prepared for any mission it’s called upon to serve.”

In previous missions, *Comfort* assisted in relief efforts in the aftermath of Hurricane Katrina. The ship also offered relief for Operation Iraqi Freedom as well as providing services for rescue workers after the September 11, terrorist attacks. *Comfort* has unique capabilities for humanitarian relief missions including helicopter lift, advanced medical equipment, a wide range of medical skills, berthing, and personnel support, as well as supplies to support medical operations ashore. ⚓

—Story by JO3 Heather Weaver, National Naval Medical Center Public Affairs.

Sailor Comes to Afghan Boy’s Rescue

After treating hundreds of casualties during a tour with the Marines in Iraq, and then treating hundreds more during his 9 months in Afghanistan, LCDR William Dave Holder, MSC, thought he had seen it all. An 8-year-old Afghan boy with a medical condition virtually unheard of in the United States quickly changed his mind. Holder, a physician assistant attached to the 3-141 Battalion Aid Station here, normally tends to U.S. service members, Afghan National Army soldiers, Afghan National Policemen and local civilians. But, the physician assistant permanently assigned to the Naval Medical Center in San Diego, also participates in weekly civilian outreach missions with Afghan National Army medics. Holder and the medical team in Ghazni processed nearly 1,000 patients in a few months of work in Afghan clinics. Many of the



LCDR Holder visits with Abdul, and his father in the Bagram hospital. Photo courtesy LCDR William Dave Holder

patients sought medical attention for wounds untreated for extended periods of time because professional care was not available.

During a weekly mission with an ANA medical battalion, Holder was asked by an Afghan doctor to assist with an Afghan boy named Abdul. “(Abdul) had what appeared to be a piece of wood sticking out of his leg,” said Holder. He soon realized it was Abdul’s shinbone.

Abdul’s story began 4 months earlier when he first injured his leg. Two months later, he re-injured the leg, causing the shinbone to protrude out of the skin. “He had a series of injuries to his leg and was hobbling around trying to bear the weight,” said Holder. “It was grossly infected—bone and skin. I decided I would get him taken care of,” he added.

Special cases such as Abdul’s are normally referred to the provincial reconstruction team medical clinic, according to Holder. In many circumstances, patients are then referred to the Egyptian Field Hospital at Bagram.

Holder said he felt compelled to personally look after Abdul. He made some phone calls and eventually talked with orthopedic surgeon and native of Bountiful, UT, CAPT Shawn Hermenau, MC, USA, at the 14th Combat Support Hospital in Bagram. Hermenau agreed to see Abdul.

It took more than 2 weeks to get Abdul a flight to Bagram because of bad weather and mission-essential flight requirements. While waiting, Holder paid the cab fare so Abdul and his father could visit the clinic each day to have the wound cleaned and dressed. When the weather cleared, Abdul and his father traveled to the U.S. hospital in Bagram where they met Hermenau and the rest of the team that would help save his leg. “When you see a kid that breaks his leg, and you get the chance to help him be able to go out and do kid stuff again,” Holder said smiling, “it gives you a ray of hope.”

Holder believes helping Afghans such as Abdul reinforces the positive relationship between Coalition forces and the local population. “Abdul is from a known trouble spot in the AO (area of operation), so hopefully this will be a good-news story for them that the Americans treated him well,” said Holder.

Because of his belief in the Coalition mission in Afghanistan and the fulfillment he gets from helping others, Holder says he lives for the satisfaction he receives from each deployment. “I came to Afghanistan to take care of soldiers and the people here and I think I did that,” he said. “I’ll come back a third time.” ✍

—Story by SGT Nina J. Ramon, USA, 345th Mobile Public Affairs Detachment.

Navy Corpsmen Keep Skills Scalpel Sharp

HN Bounmy Meunsky looked a little nervous holding a razor-sharp, stainless steel surgical instrument. It was there, hovering just a hair-breadth’s distance away from his patient’s neck. His task: cut the neck just below the Adam’s apple and shove a tube in. Sounds gruesome, but opening a blocked airway is one of the most important skills to saving Marines on the battlefield.

Hospital corpsmen from Regimental Combat Team 5’s aid station recently brushed up on two of the most important lifesaving skills, the cricothyroidotomy and the use of tourniquets. “These are the two things that keep Marines alive,” said HM1 Juan M. Rodriguez, the 33-year-old Senior Medical Department Representative. “They don’t have a lot of things in their bags, so they need to be very good with what they have.”

The corpsmen gathered around a “training dummy,” a latex mock-up of a human head, neck, and airways leading to the lungs. The first part was locating the right place to cut in the neck. Cut too far one way or the other and there’s a good chance of nicking major blood vessels leading to and from the brain.

It’s enough stress to get it right the first time that even the coolest customers can get sweaty foreheads. That’s why corpsmen constantly train with “hands-on” applications.

It’s a lot easier when you’re actually feeling around for the spot on the body,” Rodriguez explained. “Most corpsmen are hands-on anyway and the more they’re exposed to it, the easier it’s going to be.”

The sailor’s pressed on each other’s necks, locating the ring of cartilage just below the notch in the Adam’s apple. The ring of thick tissue just beneath it was their target. It was right there they’d cut and save a Marine’s life.

The practical application of feeling each other’s necks and practicing on the mannequins is essential. It’s that sort




HN Bounmy Meunsky demonstrates the proper procedure for opening an airway for LCDR Henry F. Casey, III, MC. Photo by GSGT Mark Oliva, USMC

of training that helped HM3 Ulises V. Urbina save Marines' lives in Najaf 2 years ago.

"We call it the 4 miracle minutes," Urbina explained. "You've got 4 minutes to restore breathing before brain damage occurs. 'It's like riding a bike,' added the 25-year-old. 'Once they've learned it, it's going to come back to them. I've never had a corpsman freeze up.' It wasn't just restoring breathing the sailors practiced, but also stanching blood flow. They practiced using tourniquets, everything from placement to pressure. Urbina explained it only takes a loss of a 1½ to 2 liters before shock can set.

"There are three things that sustain life," said HM3 John W. Harper. "That's the airway, breathing, and circulation. Losing any one of these can cause death, so we train to restore those as quickly as possible."

Harper is on his first tour in Iraq and is counting on these types of refresher drills to solidify his knowledge of lifesaving skills. "This training is very important for corpsmen," he said. "Without the training, there's more chance to freeze up. We put as much emphasis on this as Marines put on their rifles."

Freezing up is something veteran corpsmen have yet to see. The training regimen proved to be reliable when corpsmen took part in battles and stood up against the odds to save Marines' lives. Urbina saw it time and again during the battles in Najaf. "When the patient came in, you just knew what you had to do," he said. "It was expedient care. All the wounded who came in during the fighting in Najaf—they lived." 

—Story by GSGT Mark Oliva, Regimental Combat Team 5.



On 9 May 2006 ENS Christopher R. Moore, MSC, assigned to EMF, Camp Arifjan, Kuwait, was raising a flag in honor of his two sons. HM3 Debra Hanson snapped the picture. On a lark Moore submitted the photo to Kodak.com in the "Picture of the Day" contest. The photo "Raising the Flag for my Sons" was selected by Kodak as picture of the day for 14 June 2006, Flag Day. The photo appeared at www.kodak.com on 14 June and was shown every few minutes on the Kodak Times Square Gallery big screen in New York City.

Mercy Humanitarian Mission to Begin

The hospital ship USNS *Mercy* (T-AH 19) departed its San Diego homeport 24 April, in support of a 5-month humanitarian assistance mission to the Western Pacific and Southeast Asia.

Following logistics stops along the way, *Mercy* arrived in the Philippines in May.

The ship's mission is being coordinated with host nations in the region and is being carried out in conjunction with non-governmental relief organizations to provide medical, dental, and other humanitarian assistance programs ashore and afloat.

"The deployment of *Mercy* to Southeast Asia and the Western Pacific exemplifies the United States' commitment to working together with our friends, partners, and the regional community," said ADM Gary Roughead, commander, U.S. Pacific Fleet. "By deploying *Mercy*, we are training our medical crew in order to better prepare them to respond in times of disaster relief and armed conflict."

Mercy deployed with civilian mariners, military personnel, and members of non-governmental organizations. The *Mercy* humanitarian mission is led by CAPT Bradley Martin. The commanding officer of the medical treatment facility aboard is CAPT Joseph L. Moore. Civilian mariner CAPT Robert Wylie is the ship's master.

The medical crew aboard *Mercy* is trained to provide general surgery, ophthalmology surgery, basic medical evaluation and treatment, preventive medicine treatment, dental screenings and treatment, optometry screenings, eyewear distribution, public health training, and veterinary services.



CAPT Joseph Moore, Commanding Officer of the Medical Treatment Facility aboard *Mercy* poses with Philippine Consul General, Ariel Abadilla. Photo by JOC Stephen K. Robinson, USN

A Seabee detachment from Naval Mobile Construction Battalion (NMCB) 40 from Port Hueneme, CA, is performing civic action repair and minor construction projects in the host countries.

The Navy Showband from Norfolk, VA, will join *Mercy* while deployed. The band will provide outreach and entertainment to local populations where assistance work is taking place.

Last year *Mercy* performed a similar mission following the December 2004 tsunami that struck Southeast Asia. Medical personnel aboard performed 19,512 medical procedures for more than 9,500 patients in Indonesia, East Timor, and Papua New Guinea. "Many Americans are from the Asia-Pacific region, and we have strong ties to family members, friends, and co-workers with roots in the region," said Roughead. "It is natural we should want to be good neighbors."

Mercy can rapidly respond to a range of situations on short notice. *Mercy* is uniquely capable of supporting medical and humanitarian assistance needs, and has been configured with special medical equipment and a robust multi-specialized medical team to provide a range of services ashore as well as on board the ship. ⚓

—Story from U.S. Pacific Fleet Public Affairs

Mercy Begins Humanitarian Work In Zamboanga

The crew of USNS *Mercy* (T-AH 19) completed their first day of humanitarian work 26 May by treating more than 45 patients off the shore of the southern Philippine city of Zamboanga.

Mercy's arrival here marks the start of the real work for its 5-month deployment as the crew partners up with the host nation and non-governmental organizations that include Project HOPE, Aloha Medical Mission, and the Tzu Chi Foundation to deliver humanitarian assistance and civic aid to area residents.

Mercy's crew along with personnel from Army, Air Force, and non-governmental organizations (NGOs) started treating various diseases ranging from thyroid disease to cataracts and hernias.

"These are surgeries that we do on a daily basis in the States," said LT Stella Annunziato, NC. "These are people in need. That's why we were asked to come here and treat these people."

Rosibel Atilano, a 25-year-old Filipino girl from Zamboanga, came to *Mercy* with a thyroid problem and said she was very pleased with the treatment she received.



HM3 Adelaida Sojo visits with a local patient in the pediatric ward in Zamboanga Medical Center during *Mercy's* visit to the city. Photo by PH3 Timothy F. Sosa

"I am very happy that I'm here in the ship," said Atilano with the help of a translator. "They will operate for free—that makes me happy. (Everyone) was very helpful and accommodating."

Along with the NGOs and joint military services, *Mercy* was also joined by Filipino military translators and medical personnel.

"It's nice to work with such diversity," said LTJG Catherine Soteras, NC. "This is the first time that we've worked with Filipino officials. We will teach them (medical techniques) that are hard to translate. In turn, they can teach others what they've learned here."

For this deployment, *Mercy* has been configured with special medical equipment and a robust multi-specialized medical team of uniformed and civilian healthcare providers to provide a range of services ashore as well as onboard the ship. ⚓

—Story by JO Joseph Caballero, USNS *Mercy* Public Affairs



LCDR Elizabeth Ferrara leads Navy medical personnel currently attached to USNS *Mercy* (T-AH 19), off the ship and then on to Indonesia. The volunteers are departing *Mercy* in support of the victims of the recent earthquake. Photo by PHC Don Bray

Mercy Assists in Quake Relief

USNS *Mercy* (T-AH 19) sent a team of four Navy medical personnel 31 May to help with quake relief efforts already underway in Indonesia.

The personnel deploying from the ship will not impact its ability to complete its current mission in the Philippines that started 25 May. The U.S. military and all other organizations aboard the ship remain committed to providing the humanitarian and civic assistance as planned with the government of the Republic of the Philippines.

The deploying crew members will augment the 3rd Marine Expeditionary Force's Navy medical team to help the thousands of people affected by the quake that struck the area 27 May.

"We are giving Indonesia people with public health and primary care talents to augment the other capabilities coming in from elsewhere. We are proud to help in the relief efforts," said CAPT Joseph Moore, commanding officer of *Mercy* Medical Treatment Facility. "These people who are going forward carry the spirit of the *Mercy* with them."

The team consists of experts in various fields including preventive medicine, internal medicine, family practice, and pediatrics. ⚓

—Story by JO Joseph Caballero, USNS *Mercy* Public Affairs



USNS *Mercy* (T-AH 19) spends its first night in the Philippines anchored near Manila. Photo by PH2 Troy Latham



Halifax, Nova Scotia. HM3 Mandy Gilley aboard USNS *Comfort* (T-AH 20) reorganizes equipment after the ship's mass casualty exercise. May 2006. Photo by JO3 Heather Weaver, USN



Phramahachedsadrajao Camp, Thailand. HM3 Kamil Gorski, with Marine Expeditionary Unit Service Support Group 31, instructs members of the Royal Thai Marine Corps on how to apply a tourniquet to an injured person during a Tactical Combat Casualty Course, as part of the joint/combined forces training Cobra Gold 2006. April 2006. Photo by LCPL Raymond D. Petersen III, USMC



Jalalabad, Afghanistan. CDR Sandra Hearn assigned to Combined Joint Task Force Seven Six (CJTF-76), treats an Afghan girl with a head injury. Hearn and the medical team were on a 6-day medical civic assistance program run by Afghan and Coalition forces, more than 6,300 patients were treated. April 2006. Photo by CAPT Dan Huvane, USMC



Al Asad Air Base, Iraq. LT Alex B. Galifianakis, MC, discusses treatment with a Marine on stand-by to be medically evacuated from Al Asad Surgical. Photo by CPL Daniel J. Redding, USMC



Zamboanga, Republic of the Philippines. Dental personnel prepare the tools of their trade in preparation for a medical assistance mission at Recodo Elementary School outside Zamboanga City. Personnel are assigned to USNS *Mercy* (T AH 19). May 2006. Photo by PHC Don Bray, USN



Atlantic Ocean. LCDR John R. Lundstrom and HM3 Brittany Rosenbaum assigned to the amphibious transport dock ship USS *San Antonio* (LPD-17) perform the first dental filling in the ship's history. April 2006. Photo by JO3 Anthony C. Tornetta



Persian Gulf. HM1 Cynthia Donaldson prepares surgical instruments before an inguinal hernia repair in the operating room aboard USS *Ronald Reagan* (CVN-76). April 2006. Photo by JO2 Shane Tuck, USN



Camp Lemonier, Djibouti. HN Kimberly Cochrane demonstrates the proper way to add a pressure dressing to a wound as part of the Combat Life Saver's (CLS) Course offered by the Camp Lemonier Expeditionary Medical Facility at Combined Joint Task Force Horn of Africa. April 2006. Photo by PH2 Roger S. Duncan, USN

Navy “Docs” Focus on Keeping Marines, Iraqis Alive

Saving lives. These two simple words sum up one vital endeavor for the sailors of the Al Asad Surgical unit here. Whether it's injured U.S. service members, Iraqi Security Forces (ISF), or local civilians, this medical unit in western Iraq is fully prepared to provide treatment to those in need.

Al Asad Surgical is usually the first stop for Marines who are seriously wounded fighting insurgents in places like Haditha, Husaybah, and Al Qaim—towns in the northwest corner of Iraq that continue to be hot spots of insurgent activity. Since they assumed command in late February, the unit has handled nearly 200 patients including members of the ISF and several insurgents.

The majority of injuries the unit has treated have been from improvised explosive devices, said LCDR Ben A. Powell, NC, an en route care nurse with the unit. “In the surrounding area, Al Asad Surgical is the primary provider of extreme and timely care,” said Powell. “If Al Asad Surgical was not here, a patient's chances of survival would diminish exponentially,” he said.

There are five levels of medical care for service members in Iraq, beginning with level one, which is provided by battalion-level aid stations and ending with level five care that is provided back in the States. Al Asad Surgical provides level two medical care, the highest level of care outside of the Combat Army Surgical Hospitals at Baghdad and Ballad.

The flow for such vital care was uninterrupted as the current crew that just arrived in February had a seamless transition with the staff they replaced, said LT Joseph A. Gomez, NC, a critical care nurse with the unit. Even with the guidance from those who have been here for the past 7 months, and their intense medical schooling, the new medical personnel here know they still have much to learn.

“Nothing prepares you for this environment, experience is what is getting us through,” said ENS Maria G. Kennedy, who recently helped a 10-year-old boy from a nearby village who had suffered a serious head trauma. With each additional case the nurses are getting more proficient at providing care not only on the ground, but in the air as well.

“Al Asad Surgical provides a service that no other medical unit in the surrounding area can offer—patient stabilization during helicopter medical evacuations from Al Asad to higher-level medical facilities elsewhere in Iraq,” Powell said. “Every nurse assigned to the ‘Forward Resuscitative Surgical Suite’ (FRSS) has handled multiple cases of en-route care,” said Kennedy.

To date they have performed 17 medical evacuation flights. Sailors like HM2 Keith J. O'Brien, an operating room assistant, find a sense of satisfaction in their role in this conflict. O'Brien also works in the FRSS, which works



HM1 Ryan J. Sadler, at Al Asad Surgical, 1st Marine Logistics Group, listens to the lungs of a recovering Iraqi Security Forces service member. Photo by CPL Daniel J. Redding, USMC

hand-in-hand with the shock trauma platoon to stabilize patients, prepare them for flight, and provide in-flight care. Unfortunately, that sense of satisfaction only goes so far; the trauma that O'Brien has seen will linger in his mind for a long time to come, he said.

“I'm not going to lie to you, some of the stuff that I have seen here, just in the past month, still haunts me,” he said. O'Brien's father, a physician assistant and former corpsman, has also seen the horrors of combat and has spoken with his son about what he would see

in Iraq. “He's been doing it a long time, and he's told me how to cope with it,” he said. When his father returned from Iraq, O'Brien saw his father cry, a rare occurrence. For father and son, dealing with the emotions of handling trauma care is something they work on together. “The best thing corpsmen can do is talk it out; getting the experiences off their chests helps the sailors deal with the burden they all carry,” O'Brien said.

One Iraqi civilian O'Brien helped treat was a 2-year-old boy who had been badly scalded after falling into boiling water his family was using to wash clothes. The family brought the boy to Al Asad Surgical; his father saying, “Help me, please,” O'Brien said. “That's our job, to help people. We treated and saved his son,” said O'Brien, who has a son roughly the same age. The child was returned to the family better off than when he arrived, but O'Brien wasn't sure if the child survived after leaving the base. “I'd be surprised to hear that he didn't make it,” O'Brien said. “The healthcare providers here are phenomenal.”

A seasoned operating room assistant, O'Brien said that in light of what he has experienced in Iraq, he feels as if he just arrived out of the Navy's Field Medical Service School. “It's a really different task that we do out here,” he explained, comparing what he does stateside to the care they provide here. Back in the States, O'Brien was in charge of training for the unit, making sure all the Marines and sailors in Alpha Surgical were properly prepared for their deployment. One particularly useful course the sailors experienced was the month-long Naval Trauma Training Course with one of the busiest hospitals in the U.S., the Los Angeles County Hospital.

Although it's next to impossible to truly prepare for experiencing trauma firsthand, the wounds the sailors saw at L.A. County were an eye-opener, O'Brien said. “A lot of the stuff

experienced at L.A. County really equates to what we see here,” he said.

For these sailors, providing such necessary and urgent care is a mission that is never thankless, even if they never get the chance to hear their patients thank them personally.

“There is a lot of self satisfaction and a lot of pride in what everybody does here,” Gomez said. “To see someone leave here in a better condition than they were, it’s a feeling no one can ever explain.”

—Story by **CPL Daniel J. Redding, 1st Marine Logistics Group.**

Sailors Treat Iraqi, American Patients in Sunni Triangle

The discomfort of inhospitable conditions coupled with the fear of knowing that mortar and rocket attacks can, and do, occur at any time seem to have never existed when the “docs” of Taqaddum Surgical make the switch from having a quiet, calm, and otherwise boring day to handling the emergency needs of more than a dozen patients injured fighting insurgents.

Instinctively, nurses, corpsmen, surgeons, and Marines quickly bound from room to room, rushing blood to some patients while performing emergency surgery on others. Unpredictability and adverse surroundings are common as this small hospital serves a vital role in the Sunni Triangle, a hotbed of insurgent activity.

The unit is classified as a surgical shock trauma platoon, or SSTP, because it has two main elements: a shock trauma platoon, which serves as an emergency room, and a forward resuscitative surgical suite—a battlefield operating room. With such capabilities, Taqaddum Surgical handles the trying task of treating mass casualty incidents such as the one unfolding before them.

Small tents serve as their treatment rooms, often with temperatures hovering around 120 degrees to regulate the patients’ body temperature during treatment. Their tents’ tarp canvas offers minimal protection from the sandblast affect of the wind and the unforgiving heat of the desert sun.

The Iraqi Army had several soldiers wounded in an insurgent attack that also hit two American service members attached to the unit’s Military Transition Team. The MTT is a small group of American military personnel tasked with training and advising Iraqi soldiers. For the staff of Taqaddum Surgical, patients are viewed as just that—patients—regardless of their nationality, said LT Lane C. Zeitler, a nurse with the surgical unit. There is no time to see anything more than a member of the multi-national forces urgently needing treatment, he explained.


When a mass casualty incident occurs, the sailors and Marines here must react instinctively; there is little time to do anything more than the next necessary step for their patient’s survival. As they intensely concentrate on their mission in the treatment rooms, the sailors still get a glimpse of the progress being made on the frontlines, said Zeitler. “[In here] it looks like the transfer of power is happening,” said Zeitler, referring to the fact that Iraqi casualties outnumbered U.S. Although the attack left several wounded, some feel these instances serve to strengthen their resolve. “We are fighting as one team,” said LCOL Abdulmajeed, who chose not to give his full name. “We fight together. We are injured together. We try to build this country together.”

Abdulmajeed, a surgeon, has served with the new Iraqi Army for more than 3 years and has seen the ebbs and flows of the insurgency and has also seen his country’s army improve, he said, thanks to the work of U.S. service members like MSGT Jay L. Lilleflore, the MTT’s senior enlisted advisor. “The Iraqis are forming a solidified, independent army with the support of the American advisors,” said Lilleflore. He added that as the Iraqis take a more significant role in the fight, they continue to see themselves as working right alongside the Americans instead of the supporting role they had earlier in their development. “The MTT members wholeheartedly return the sentiment,” said Lilleflore. “There is a personal bond that tends to happen when you’re getting shot at,” he added, as he and several Iraqi officers waited anxiously for updates on their injured troops. “The bond formed by the combat action and rigorous training has begun to slowly blur the line between the Iraqi soldier and U.S. Marine,” Lilleflore said. “There’s only 10 Marines out there and 200 jundi (junior enlisted Iraqi soldiers),” Lilleflore said. “It’s like having 200 Marines.”



HM3 Joshua W. Bromley and HM3 Jesse K. Bolstad, corpsmen at the Camp Taqaddum, Iraq, main surgical facility, take a breather as other medical personnel continue working on service members wounded during an insurgent attack in Iraq’s Al Anbar Province.
Photo by 1st LT Robert E. Shuford

“Regardless of whether a soldier is Iraqi or American, it’s a confidence booster for them knowing Taqaddum Surgical is close by,” Lillefloren said. “You can get hurt out there and treatment is minutes away,” he said, adding, “You never know what’s going to happen out there.”

When asked about the amount of blood covering his smock, whether it was Iraqi or American, one doctor said “it doesn’t matter, they’re all patients.” 

—Story by CPL Daniel J. Redding, USMC.

Iraqi Soldiers Hone Lifesaving Medical Skills in Al Anbar Province

Tucked neatly inside the Marines’ base here is an Iraqi army camp, where Iraqi soldiers are training day and night to learn the skills they’ll need to eventually relieve coalition forces of security operations in Iraq.

The Iraqi soldiers here—part of the 2nd Brigade, 7th Iraqi Army Division—have spent months learning everything from basic marksmanship to administration and now, medical evacuation and treatment. Most recently, the soldiers here received arguably some of the most crucial training they’ll need to survive in western Al Anbar Province—how to deal with a “mass casualty” event. A “mass casualty” is defined by U.S. military medical personnel as a catastrophic event that results in a number of casualties which could possibly tax a unit’s medical staff and equipment. Instead of treating casualties as they find them, first responders must pool their resources, prioritize casualties’ wounds, and treat them accordingly to save as many lives as possible.

“They’re going to get injured, and the better they respond to it, the more people they’re going to save,” said HM1 Krishna J. Reyes, a 16-year Navy corpsman and member of the Military Transition Team (MTT) staff here. MTTs are groups of coalition service members assigned to track and guide each Iraqi military unit’s transition to full control of security operations in Iraq. Marines from Regimental Combat Team 7 (RCT-7) spent more than 50 days at Camp Yasser, the Iraqi unit’s camp here, evaluating and advising Iraqi soldiers.

The mass casualty drill in March was another building-block in the Iraqi’s progression toward independent operations, which MTT leadership here say will happen by year’s end. Corpsmen from RCT-7, role-playing wounded casualties, offered a touch of realism during the exercise for the Iraqi soldiers. Sprawled in various rooms of an unlit, wooden hut, the sailors moaned in agony while wearing injury-bearing rubber prosthetics. The uniformed Iraqis were required to locate, prioritize, and evacuate the casualties while under the watchful eye of the MTT staff and a Navy surgeon. The training is considered crucial for troops here because a

proper first response can mean the difference between life and death in a real mass casualty situation.

“Anyone can load a patient [on an ambulance] or put on a bandage when they have all the time in the world,” said Reyes. “That’s why we train to do it quickly—because we won’t have time.”

The soldiers had to accomplish three tasks during the exercise—control the bleeding of patients, provide area security, and evacuate and treat the patients. With the constant possibility troops can run into the threat of small arms fire and improvised explosive devices on Anbar’s dangerous roads, immediate, life-saving medical treatment is a must for the Iraqi Army.

To add to the scenario’s intensity, the wooden hut also contained mock unexploded ordnance, which meant the Iraqi soldiers had to quickly evacuate the patients before treating them and before sustaining more casualties from a possible secondary explosion. Reyes said the drill was designed to be tough and keep the Iraqi soldiers under pressure, adding a touch of realism to what they’ll experience in the event of a real mass casualty event, whether an indirect fire attack on their base, an IED attack on a convoy, or any number of scenarios which could cause a high volume of casualties.

That was something Iraqi Army medic and Warrant Officer Ahmed Jubal was hoping to avoid when he and his cadre of soldiers arrived at the wooden structure littered with moaning, bleeding “casualties.” “We learned today how to stop the bleeding, use IVs,” said Jubal through a translator. “I’m confident because we treat the injured like real. We take it serious.”

The training gave Iraqi soldiers a taste of the intensity and split-second decision making needed to quickly evacuate and assess casualties’ wounds, and gave MTT staff members an idea of the Iraqi soldiers’ response capabilities.

Within minutes of the mock casualties’ moaning in false pain, a blaring siren grew louder as Iraqi soldiers sped to the scene in their ambulance. Within minutes, the ambulance pulled in front of the building, Iraqi soldiers poured out of the vehicle, evacuated the casualties, and began the treatment process. By the 30-minute mark, they had successfully evacuated and treated the mock casualties—who had simulated burns, fractures, and severe blood loss—with minimal assistance from the Navy medical staff.

“They did a remarkable job; even more remarkable when you consider there was only one medic and a bunch of Jundi (Iraqi soldiers) with limited medical training,” said CDR Jay Erickson, RCT-7’s surgeon, who observed the drill and gave pointers through a translator to the only Iraqi medic on the scene. “I was expecting them to take a step back and become overwhelmed,” said Reyes, who was impressed at just how well the Iraqi soldiers performed.

One issue the MTT members hoped to bring to light to Iraqi Army leadership through the scenario is the need for additional



Iraqi soldiers lift HM James J. Campbell, a mock “casualty” role-player, onto a stretcher before loading him into an ambulance during a mass casualty drill at the Iraqi Army camp at Al Asad, Iraq. Photo by SSGT Jim Goodwin, USMC

Iraqi medics for the battalion. During the exercise, only three of the Iraqi soldiers are bonafide, trained Iraqi military-certified medics. Three medics for an entire unit is simply not enough, said Reyes. That’s why plans are in the works for the MTT staff to begin a training program here that will qualify, per Iraqi Government standards, Iraqi soldiers as medics. The plan is to provide 2nd Brigade and its three subordinate battalions throughout Al Anbar Province with about 150 more medics within a year.

“To have one guy who can focus on one patient with a restricted airway, for example, would be golden,” said Erickson.

As part of the MTT staff here, Reyes has spent over 2 months advising soldiers of the 2nd Brigade in their daily training regimen, which includes everything from basic marksmanship to the decision-making processes they’ll need to function as a military headquarters element. He also squeezes in medical training to the enlisted Iraqi soldiers, known as “Jundi” (pronounced “JUNE-dee”), during their training to familiarize them with medical equipment and combat lifesaving techniques. “They’re eager to learn,” said Reyes. “They want to perform, and they are.”

Following the exercise, the Navy medical staff gathered in another wooden hut to discuss the soldiers’ performance. Though the Iraqis did make mistakes, the Navy medical team and MTT staff were impressed with what they saw, especially considering only one of the Brigade’s three medics participated. In contrast, Erickson used a U.S. military comparison to put the Iraqi soldiers’ performance in perspective for the handful of corpsmen that role-played casualties and observed the drill. “Guys, think about it. If that had been 30 Marines out there and just one of our corpsmen, how would you do?” asked Erickson of his corpsmen during the debrief. One corpsman was quick to respond—“Not that good!”

Eventually, the unit will be tasked with taking charge of three Iraqi Army infantry battalions and expected to operate independently later this year, according to U.S. military leadership here.

The mass casualty drill came on the heels of another recent Iraqi Army achievement in western Al Anbar Province. The week before, about 100 Iraqi soldiers from the 2nd Brigade’s 2nd Battalion, completed their first, fully-independent counterinsurgency operation in Khaffajiyah, a village south of the town of Haqlaniyah along the Euphrates River.

The soldiers, who were accompanied by a handful of Marines in an advisory role only, patrolled through and cleared 3 km of the village. The battalion of Iraqi troops are partnered with a Marine infantry battalion in the “Triad” area of Haditha, Haqliniyah, and Barwanah. Coalition forces leadership deemed the operation as a milestone in the Iraqi Army’s progress.

“The soldiers were very happy ... because after all the training we went through, we finally were going to get a chance to prove ourselves,” said Iraqi Army SGT Ahmad Mdtr of 2nd Battalion following the operation. “This is our one chance to prove that we can do our duty alone.” ✍

—Story by CPL Adam C. Schnell, USMC, 3rd Battalion, 1st Marine Combat Correspondent.

26 MEU Trains to Save Lives

Marines never leave another Marine behind. Because of this powerful commitment, the Marines and sailors of the 26th Marine Expeditionary Unit spent the morning at Camp Johnson, NC, weaving through concertina-wired pits and waist-deep trenches while carrying a 150-pound training dummy on a field stretcher, better known as a litter, during the Litter Bearer Obstacle Course, 20 March.

The course is designed to simulate evacuating injured personnel in a combat environment.

“We wanted to get the Marines out here to learn the process and difficulties with evacuating their injured,” said CDR Matthew A. Carlberg, MC, 26th MEU Surgeon.

One of the difficulties Carlberg wanted the Marines to understand was the physical demand it takes to carry a 150-pound dummy through the course.

At different areas of the course, the Marines were required to lift the dummy to shoulder height to move it through an obstacle course and other areas. They had to rotate the simulated victim so the feet or head was in the lead.

The Marines faced more than fatigue, water, and concertina wire during the training. At random points in the course, they were required to simulate protecting their wounded during attacks.

“We wanted to give them a realistic sense of what could happen,” said HM1 Shawnreno Ricks, 26th MEU corpsman. “We wanted to show what you have to do when firing is going on overhead and you still have to move forward.”

A realistic sense is what some Marines will most remember about the course.



Marines of the 26 MEU move their litter under a concertina wired pit during training. Photo by SSGT William T. Kinsey

"The hardest part of the training was the freezing water and the mud," said CPL Chris D. Gunlefinger, an administrative clerk for the 26th MEU. "It was a very rigorous course."

After the Marines and sailors had completed the course, they returned to their headquarters, taking with them a positive perspective of the training.

"If you get the chance, do it," said Gunlefinger. "It's good to get out of the office and be a Marine."

Ricks felt the training was an overall success in teaching the Marines what most hospital corpsman have to endure in a combat environment.

"Everyone was willing to do the training and if you're willing to do it, you'll get more out of it," said Ricks.

The Marines of the 26th MEU continue to prepare for the upcoming training cycle scheduled to begin in June. The cycle will prepare the Marines for a 2007 deployment in support of the global war on terrorism. ⚓

—Story by SSGT William T. Kinsey, Marine Corps Base Camp Johnson, NC.

Sailor Recognized for Superior Efforts

Marines and sailors are expected to get the job done in and out of uniform at home and abroad.

In the case of HM2 Melissa D. Cornell, executive assistant for 1st Marine Expeditionary Force Command Master Chief Raphael Sanchez, her efforts have recently been recognized.

"You get leadership qualities [in the military] that are invaluable...work ethic, a life ethic, that can't be obtained anywhere else," said Cornell, 34. Cornell has won four Navy boards at Camp Pendleton: 4th Quarter Junior Sailor of the Quarter and Junior Sailor of the Year 2005 for both I MEF and the 3rd Marine Aircraft Wing.

She was also named the 2005 San Diego Naval Services Woman of the Year on 29 March. The Navy League of San Diego, which formed the selection committee, took several things into account when reviewing 36 female applicants from all branches of the service. The application requested a breakdown of professional achievements, community involvement, and an essay on what military service means to them.

"When the members of the board started reading into the lives of the applicants they were amazed with what these women were doing," said Jay Lott, executive administrator

of the Council of the San Diego Navy League and a retired Marine sergeant major. "[Cornell] was a unanimous choice with all the members of the selection committee."

Despite the recent praise, she tends to downplay her actions. "We do what we have to do... The people who have the hardest job are those that support the service members, like family members," Cornell said. "The separation from family and the long hours are hard on us, but it's hardest on them."

She said that her family, especially her son, and her command have helped her excel as a sailor, regardless of what kind of "proverbial hat" she's wearing. "The bottom line is you make your own path, set your goals, lay the foundation and pave the way," she said. "It's up to you whether it's gravel, cobblestone, concrete, or carpet."

She prefers concrete, and her vehicle of choice is a pearl-white, 2001 Harley Davidson Sportster.

She is currently enrolled at Thomas Edison State College and is just a few credits shy of a bachelor's degree.

In March 2005, Cornell received the Navy and Marine Corps Commendation Medal with Combat Distinguishing Device for service in Iraq as a casualty evacuation corpsman on Mercy 02, a CH-46 Sea Knight helicopter, with Marine Medium Helicopter Squadron 268, Marine Aircraft Group 16, 3rd MAW.

Mercy 02 received notice to launch on an urgent casualty evacuation mission in support of Operation Al Fajr for 1st Marine Division, 1st Marine Expeditionary Force, on 11 November 2004. Her helicopter sustained small arms, rocket-propelled grenade, and anti-aircraft artillery fire during the evacuation. Its escort, an AH-1 Super Cobra, sustained hits that forced it to an emergency crash landing. The CH-46 maneuvered back to the engagement area and landed at the crash site. Cornell dashed out of the helicopter and provided rear security as the Cobra pilots boarded her aircraft. She then gave the pilots initial medical treatment en route to Al Taqqadum, Iraq.

While in Iraq, Cornell flew more than 80 missions and treated more than 100 battlefield casualties.

At Marine Corps Air Station Yuma, AZ, Cornell was the senior medical department representative in charge of providing medical support to more than 3,000 Marines.

"It's important for us to do our jobs at home because that work supports those forward deployed," Cornell said.

She has assumed the role as Camp Pendleton's education and training petty officer for Marine Aircraft Group 39, ensuring that all staff members and units within MAG-39 receive basic life support training.

Cornell has re-certified one emergency medical technician, instructed six corpsmen on their way to the Enlisted Fleet Marine Force Warfare Specialist designation, and devoted numerous hours teaching combat lifesaver courses for more than 50 Marines.

"She loves to teach classes for the Marines and sailors here, and they like to hear about her combat experience," said HM1 Gregory A. Williams, leading petty officer at the MAG-39 medical clinic. "For the combat lifesaver course, in

particular, Marines actually request that she comes down to teach more of the classes.”

As an assistant supply petty officer at Camp Pendleton, she maintained accurate accounting of the annual budget. She acquired excess medical supplies, enough to provide three deploying squadrons with gear, without using the clinic’s limited budget.

She has also dedicated more than 15 off-duty hours to prepare three squadrons here for the recent commanding general’s inspection program. All three squadrons received a “mission capable” grade.

Along with contributing off-duty hours in the workplace, she also takes the time to become involved in the surrounding civilian community.

She was involved in the 2005 Toys for Tots drive and the Brother Benno’s Toy Collection Drive last year during the holiday season.

“She takes on every challenge, every task, she can and excels at whatever she’s doing,” said Williams, who worked alongside Cornell at the MAG-39 medical clinic from August 2005 to March 2006.

Cornell, an avid motorcycle rider, participated in a diabetes awareness motorcycle ride in October 2005 and a bone marrow drive here on base. She also took part in a Horizon Christian Fellowship Ride to raise money for the organization.

Cornell also volunteered her time walking and training dogs for the San Clemente-Dana Point Animal Shelter February-July 2005.

Through her many honors and achievements, Cornell has received the respect of her fellow sailors.

“It’s a great honor for her to be recognized in that manner,” said I MEF Command Master Chief Raphael Sanchez. “We’re proud to have Cornell as part of the MEF, representing Navy medicine and the Navy, and all her hard work is due to her efforts and how she takes care of other service members. She’s a warrior through and through.”

—Story by LCPL Ben Eberle, USMC.

Hospitalman Third Class Nermin Tepic

I was born in Sarajevo, Bosnia. My father was a general-select in the Bosnian Army, and he also worked as a dean at the Philosophical University of Sarajevo. When the war started, I was 12 and the house we lived in was on the frontlines. When the Serbian offensive began, we had to leave—my mother, my brothers, and I. We left our dad behind to serve in the army, and didn’t see him until 2 years later.

I was helping out in the Bosnian Army, running information, acting as a courier up to the frontlines. I did it because they gave me food. I didn’t really understand the conflict; I just knew the Serbs were the bad guys, and they were killing

all of us. There were concentration camps—two of my uncles died there; it was a mass genocide.

When I was 14, my mom was killed by a 120mm mortar. After that, my dad started making plans for me to leave. He knew about the underground passage that was dug beneath the Sarajevo airport; we passed through, and when we got to the other side, there was a jeep waiting for us. My younger brother and I were taken to Croatia, and I started working on our papers to go to the U.S. I was 16 when I came to the U.S. to live with my uncle.

My dad died in Bosnia. After most of my family died, I didn’t feel any kind of connection to Bosnia. This is my new home, and it’s given me everything. When 9/11 happened, I decided joining the military would be the right thing to do. I had lost everything in my old country, and basically had everything in America. I would have a chance to do something exciting, and at the same time do something for my new home.

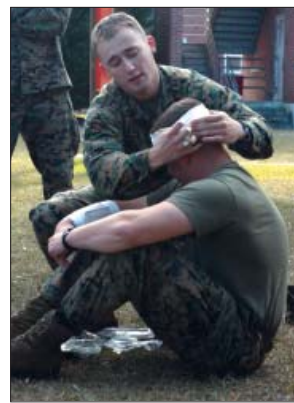
I went to the Marine Corps recruiting office, but they told me if I wanted to be a medic, I had to go across the street to the Navy. Now I think of myself as a Marine with a knowledge of medicine. I want to go to medical school, and I’d like to stay in the Navy as a doctor.

It’s a very, very close relationship between a corpsman and his Marines. You’re like their mother and father and big brother all in one. Somebody is sick, you help them; somebody’s wounded, you help them. Even if you don’t succeed, you know you did your best for that Marine. I believe the corpsman should be the most fit person in any unit, because if a Marine goes down, the corpsman should be able to carry him and still be able to keep up with the others. The corpsman has to be able to run back and forth to all the Marines and make sure they’re doing all right. We’re paid to think; we have to understand what the mission is and know that if a Marine goes down we have to run to get him, treat him, and get him back on the line to complete the mission.

I’ve been deployed to Iraq during Operation Iraqi Freedom, I was deployed twice to Afghanistan and I’ve extended my tour to go back to Iraq again. The war there is totally different from what I went through as a child. Bosnia was a dirty war. In the war we’re in now, the people have the full support of American troops. We’re trying to help them as much as we can.

HM3 Tepic is assigned to the 2nd Marine Division, Camp Lejeune, NC.

—Story by CPL Lana Waters, USMC.



Heroics Earn Corpsman Bronze Star

The morning of 4 October 2005 had a different feel than other mornings Company L had experienced in Iraq, said 2nd LT Matt J. Hendricks, Weapons Platoon commander.

Sensing the anxiety in the air, he approached HM3 Nathaniel R. Leoncio, serving as platoon corpsman, 4th Platoon, Company L, 3rd Battalion, 7th Marines, 2nd Marine Division. "That morning, right before we pushed off, I approached Leoncio and said, 'You're the angel on my shoulder.' He said, 'Yeah, you're mine too, sir,'" said Hendricks.

Those statements were foreshadowing of events to come, which ultimately earned Leoncio a Bronze Star on 7 April during a ceremony at the Naval Hospital Camp Pendleton. The mission that morning was to patrol dirt roads in unincorporated areas of southern Ar Ramadi in search of weapons and insurgent activity as part of Operation Bowie.

Their convoy was hit by multiple improvised explosive devices, the first of which disabled Leoncio's vehicle, killing the driver and severely injuring three others including him. First LT Bradley R. Watson, executive officer for Company L, pulled Leoncio from the wreckage while Leoncio instructed him how to apply a tourniquet to his severely injured right leg. The 24-year old from Temecula, CA, also sustained a shattered femur and severe internal bleeding from the blast.

"To have the medical awareness to know how to treat his wound, and for corpsmen 12 trucks, 6 trucks, 3 trucks back (from the explosion), that's outstanding. To be in the vehicle that's hit, that's amazing," said CAPT Rory B. Quinn, commander of Company L. "Doc Leoncio is an inspiration to Lima Company."

After helping Marines treat his own wounds, Leoncio turned his attention to Hendricks, his platoon commander, who was bleeding profusely.

He winced as he rolled onto his injured right leg to reach for the field dressing in his left cargo pocket, but he successfully stopped the bleeding, according to Quinn.

Leoncio's right leg had to be amputated, and he went through the initial stages of his recovery at the National Naval Medical Center, Bethesda, MD. "It was amazing to see him," said Lindsay S. Chavez, his sister. "He doesn't let anyone feel sorry for him, and he tries to make everyone comfortable. He hasn't ever looked back on what happened and regretted it," she added.

"He's always been a get-down-to-business kind of guy," said HN Chris C. Webster, a hospital

corpsman with 1st Marine Logistics Group. "It paid off out there."

"All evil needs to succeed is for people to stand by and do nothing," said LGEN John F. Sattler, Commanding General for the 1st Marine Expeditionary Force, before pinning on Leoncio's Bronze Star. "I think everyone will agree with me, as we're here with this warrior, that evil is going to have a tough time."

As Leoncio looks towards his future, the outlook is bright. "I'm going to go back and finish school," he said. "I'll probably do something with medicine." ✍

—Story by LCPL Ben P. Eberle, USMC, Marine Corps News.

Corpsman Awarded Silver Star

HM2(FMF) Juan M. Rubio, 32, was awarded the Silver Star 27 April for conspicuous gallantry against the enemy 1 January 2005, while serving as a Marine Platoon corpsman in support of Operation Iraqi Freedom (OIF).

The Silver Star is the Navy's third highest award for gallantry in combat, following the Navy Cross and the nation's highest award, the Medal of Honor.

RDML Thomas R. Cullison, MC, commander, Navy Medicine East and commander, Naval Medical Center Portsmouth, VA, made the presentation in front of Naval Hospital Corpus Christi, TX.

During the ceremony, Cullison spoke about the bond that Navy medicine, particularly corpsmen, share with Marines. "When we serve with the Marines and the Marines are with us, it's a relationship that you can find nowhere else. The acceptance between these two groups is like no other," emphasized Cullison. "The responsibility that we put on our young corpsmen in battle to perform and to save lives is incredible."

Clarifying that point, Cullison compared the controlled environment that he and other surgeons work in with the help of many others. "Young corpsmen who go to Field Medical Service School—usually straight out of high school—perform to save lives in combat, just as HM2 Rubio did, and they are amazing!" he said.

Representing the Commanding General, 1st Marine Division, MGEN R. F. Natonski and CMC Kelvin Carter hand-carried the award to Texas from Camp Pendleton, CA, and assisted Cullison with the presentation. He also brought a personal message with him for Rubio. "I talked to all the Marines and sailors in Iraq before I left, and those back in Camp Pendleton, and they want me to tell you, 'good job, and outstanding job!' They are damned proud of you," he said. "Please continue what you have done for our great nation, the Marine Corps and Navy team, and also for the Hospital Corps community."





RDML Cullison makes the presentation of the Silver Star to HM2(FMF) Rubio. Photo by Bill W. Love


Rubio had already earned the Purple Heart for wounds sustained in the 1 January 2005, engagement while serving with 4th Platoon, Small Craft Company, 1st Marine Division, I Marine Expeditionary Force, U.S. Marine Forces Central Command.

The citation accompanying his Silver Star detailed how a well-implanted and determined enemy ambushed Rubio and members of his team along the Euphrates River in a complex attack. As Rubio and an assault element swept through the ambush site, insurgents detonated an improvised explosive device. Rocket-propelled grenades and machine gun and small-arms fire followed immediately after the explosion, wounding three Marines. Realizing the severity of the Marines' wounds, and bleeding profusely from his own, Rubio low-crawled across open terrain, exposing himself to enemy fire to provide triage. Simultaneously taking care of three urgent surgical casualties, Rubio coached his fellow Marines who were assisting other casualties as incoming enemy fire intensified.

After stabilizing the wounded for casualty evacuation, Rubio directed the platoon to provide covering fire as he and several Marines began moving the casualties toward safety. Without regard for his own life, he once again exposed himself to the heavy and accurate enemy fire, moving the Marines from the ambush site to the shoreline. Rubio's Silver Star elevates him to a distinctively exceptional category of valor among corpsmen since the commencement of Operation Enduring Freedom (OEF) and OIF. Only two others have been awarded the Silver Star. None have received the Medal of Honor, and only one hero has been presented the Navy Cross.

Rubio does not consider himself a hero, though. While addressing the audience, he revealed who he believes are the true heroes, mentioning his two sons by name and that of the mortally wounded Marine LCPL who shielded Rubio from 90 percent of the IED's shrapnel during the engagement. "When people ask me what it is like to be looked upon as a hero, I don't see myself as such, because

Joshua and Mathew and every son and daughter who's out there and who has family members in Iraq, they're the heroes," he acknowledged while fighting back emotion. "They're the ones who sacrifice their fathers and their mothers. That takes honor, courage, and bravery to go home every night and pray that their fathers and mothers come home safe.

"And Brian Parrillo, this is for you, brother," he said. "Thank you for bringing me home." 

—Story by **Bill W. Love**, *Naval Hospital Corpus Christi Public Affairs*.

Navy Medical Unit Critical to Lifesaving Efforts in Iraq

In Iraq's Al Anbar Province, coalition forces fight terrorists and insurgents daily. For a group of sailors at this sprawling logistics base, casualties from this fighting are an expected part of daily life as they strive to save those service members wounded in the heat of battle.

For the Navy "docs" at Taqaddum Surgical, an advanced battlefield medical facility here, it's a welcomed burden and way of life they willingly endure every day of their deployment in support of Operation Iraqi Freedom. On call around the clock for anything that may occur, the sailors are in a constant state of readiness.

"You never really know when casualties are going to come in," said CDR Richard L. Schroff, MC, the officer-in-charge of Taqaddum Surgical. "There are periods that are quiet, but there is never really an end to the day (for us)."

Since the unit took command of the facility 3 March, Taqaddum Surgical has handled more than 150 patients, to include more than 20 Iraqi soldiers, a few locals and even several insurgents.

As personnel from 12 different stateside commands came together here in Iraq to fill the unit's ranks, there was little time to learn new faces before getting straight to work, said Schroff, who also serves as one of the general surgeons here.

The sailors were forced to quickly work as a cohesive unit to save lives, which is a task they eagerly undertake. "Everyone is so driven to save the patients, there isn't any conflict in getting the mission accomplished," Schroff said.

When a service member is injured in battle, two needs must meet before further treatment can be given—stabilize the patient's ability to breathe and stop any traumatic bleeding. The treatment begins immediately at the scene of injury, with basic care administered by a corpsman or any available



LTs Robert Spencer and Kristian Sanchack, along with HM1 James Wallace and HM3 Jesse Bolstad, quickly transport a wounded service member from the treatment room to the ambulance. Photo by CPL Daniel J. Redding, USMC

service member with the ability to provide basic medical attention in the heat of battle.

Once stabilized, the wounded service member is then transported to either a battalion aid station or a higher level facility like Taqaddum Surgical, depending on the situation and location of the battle, Schroff said.

The military classifies Taqaddum Surgical as a surgical shock trauma platoon, or SSTP, because it has two main elements: a shock trauma platoon, which serves as an emergency room, and a forward resuscitative surgical suite—a battlefield operating room. Upon arrival at the SSTP here, the wounded are quickly searched and cleared of any possible weapons then receive specialized resuscitative treatment at the makeshift emergency room, which includes providing blood and stabilizing breathing.

The unit often sets up walk-in clinics for blood donation, called walking blood banks, when emergency blood is needed. An email will go to the entire base asking for the particular blood type needed for a wounded service member. The sailors never fail to receive overwhelming support from potential donors trying to do their part by giving a pint of blood, said Schroff.

“The response we’ve gotten from the base is incredible,” said Schroff. “Every time we put out a request, we have donors in 5 minutes. There are buses suddenly lined up.” Since their arrival the unit has activated the walking blood bank seven times, said Schroff.

Once the patient has been stabilized, he is sent next door to the operating room if he needs immediate surgery. If more advanced care is still needed, the patient is then flown to a Combat Army Surgical Hospital at Baghdad or Ballad.

Just as medical personnel are highly respected by fellow service members for their emotionally painful and lifesaving

duties, Schroff returns that respect to those he cares for, having deep admiration for those on the frontlines.

“I have a lot of appreciation for those guys outside the wire,” said Schroff, 43. “I think their job is a lot harder than what I do.”

—Story by **CPL Daniel J. Redding, USMC, 1st Marine Logistics Group.**

CNO Names 2006 Shore Sailor of the Year

Chief of Naval Operations (CNO) ADM Mike Mullen named HM1(FMF/DV) Jeromy M. Cronin the 2006 CNO Shore Sailor of the Year during a ceremony at the Pentagon, 25 May.

Cronin was chosen from among four nominees and will return to the Pentagon in July to be meritoriously advanced to the rank of chief petty officer along with the Pacific Fleet, Atlantic Fleet, and Reserve Force Sailors of the Year. Before the announcement, Mullen reflected on the history of the Sailor of the Year ceremony and the importance of distinguishing great sailors throughout commands around the world.

The CNO continued by challenging all four sailors. “From this moment forward, and certainly when you get to the point when you are wearing khaki, my number one challenge to you is leadership,” he said.

He related his top three priorities: sustaining combat readiness, building the fleet, and developing future leaders as part of that challenge saying, “How you carry those out is an important part of your leadership.” Concluding his remarks, he said, “It is a noble profession in which we serve. To you and your families we are grateful.”

Upon receiving the honor from the CNO, Cronin thanked and recognized his wife’s sacrifice and commitment over their last 12 years of marriage. He also expressed his gratitude toward the many sailors he works with, recognizing the sailors he competed against for the top honor, as well as the CNO, Master Chief Petty Officer of the Navy (MCPON), commanding officers, and command master chiefs in attendance.

“In my 13 years, I never thought I would be standing in the Pentagon courtyard among such great sailors,” Cronin said. “Everything we do, what we’ve done, or where we have been—we’re sailors first and foremost.”

When asked by the CNO what Cronin thought brought him to the position he was in today, he said, “I didn’t set out to become 2006 CNO Shore Sailor of the Year. It’s just something that happened. You go about your day-to-day business and do the best that you can do.”



HM1 Jeromy M. Cronin delivers his remarks after being announced the 2006 CNO Shore Sailor of the Year. Photo by JO1 Brandon W. Schulze

Cronin was nominated for the CNO Shore Sailor of the Year honor by Naval Education and Training Command and currently serves as a high-risk instructor at the Naval Diving and Salvage Training Center in Panama City, FL. ⚓

Story by MC1(SW) Brandon W. Schulze, Master Chief Petty Officer, Navy Public Affairs.

2006 Reserve Sailor of the Year Selected

The U.S. Navy Reserve selected as the 2006 Reserve Sailor of the Year HM1 David L. Worrell, who served under fire with the Marines in Operation Iraqi Freedom. The ceremony that held at Henderson Hall, Arlington, VA was 27 April. Chief of the Navy Reserve Force VADM John G. Cotton and a board of five force master chiefs selected Worrell. Worrell was the lead petty officer for 3rd Battalion, 25th Marines, Regimental Combat Team 2, 2nd Marine Division and is assigned to Navy Operational Support Center, Akron, OH.

Worrell was chosen from among five finalists and 43,000 enlisted Navy Reservists nationwide and in service around the world. Worrell works as a department manager at a hospital, served 7 months in combat in Al Anbar, Iraq. He oversaw the setup of temporary medical aid stations, repeatedly participated in patrols that came under insurgent attack, helped hunt for land mines and rendered life-saving medical aid to dozens of wounded Marines.

"I am extremely humbled," he said. "I was the last one of the group of finalists that I felt was going to get this award. It could have been any one of us. You all deserve it." He will be meritoriously promoted to chief petty officer in a ceremony in the courtyard of the Pentagon in July.

"Worrell stands as a well spoken, energetic sailor and combat veteran who represents the best among Reservists," said Cotton. Navy Reserve Force Master Chief David R.

Pennington, who oversaw the selection board, said the five finalists were well-rounded sailors, each of whom received the Navy/Marine Corps Commendation Medal for their achievements. According to Pennington, each has broadened their mind, given from their heart, worked with their hands, and worked in tough job assignments. "Worrell had a little of everything," Pennington said. "He is a fantastic ambassador for the Navy."

Worrell joined the Navy Reserve 3 months after he left the active component and says he enjoys the different opportunities the Navy Reserve has offered him. "I absolutely love it," he said. "I wouldn't want to do anything else. I like the camaraderie and the teamwork in the Marines. It's has a lot more job satisfaction." ⚓

—Story by MC2 Barrie Barber, Commander, Navy Reserve Force Public Affairs.



NHCP Sailor Receives U.S. Citizenship

HM3(FMF) Weld-ekiros Aregawi, became an American citizen 28 March during a ceremony at the San Diego Convention Center. Aregawi is a general duty corpsman in the Internal Medicine Clinic at Naval

Hospital Camp Pendleton.

Aregawi, originally from Ethiopia, moved to Minneapolis, MN, in November of 2002 after winning a visa lottery. Overcoming many cultural differences, including language barriers, Aregawi enlisted into the Navy in April 2004. After successfully completing Navy boot camp, Naval Hospital Corps School, and Field Medical Service School, Aregawi checked on board Naval Hospital Camp Pendleton in September 2005. Recently returning home from a 7-month deployment to Iraq with 3rd Marine Air Wing, he has dreams of becoming a physician assistant.

—Naval Hospital, Camp Pendleton Public Affairs Office

Commander, Navy Medicine West Visits CFAY Medical Personnel

RDML Brian G. Brannman, Commander, Navy medicine West visited the western Pacific recently, met with senior leaders throughout the region, and toured medical treatment facilities.

Brannman spoke with the forward-deployed naval forces in Yokosuka, Japan in a televised interview at Commander Fleet Activities, Yokosuka. Since his visit, sailors and Marines from USS *Essex* (LHD-2), USNH Okinawa, USNS *Mercy* (T AH 19), and elsewhere are once again deployed to assist in humanitarian relief in the region, in the wake of the recent earthquake in Indonesia.



—Story by **Bill Doughty**, *Commander Fleet Activities, Yokosuka, Public Affairs*



Secretary of the Navy Dr. Donald C. Winter, presents the Bronze Star to HMCS Reginald C. Dean, at Naval Hospital Pensacola, 1 June 2006. Dean received the medal for heroic action while serving with an Army unit in Iraq. Photo by

Gary Nichols



GAITHERSBURG, MD. As part of the CNO's Community Outreach program, RDML Carol Turner, Commander, DC, Naval Medical Education and Training Command (NMETC), attended Gaithersburg High School's NJROTC Awards Ceremony and Change of Command on 20 May. During the event, Turner and LCDR Skip Gainor, NJROTC Senior Naval Science Instructor, presented a NROTC college scholarship check to Cadet/Ensign Marco Herbas. Photo by HM1 Stephen Oreski

RDML Thomas R. Cullison has been nominated for appointment to the rank of RADM. Cullison is currently serving as Commander, Navy Medicine East/Commander, Naval Medical Center Portsmouth, VA.



HM3 Lee Hamilton Deal, 23, of West Monroe, LA, was killed 17 May as a result of enemy action in Al Anbar Province, Iraq. Deal was assigned to Regimental Combat Team-5, 1st Marine Expeditionary Force (Forward), and permanently assigned to 2nd Marine Division Fleet Marine Force Atlantic, Camp Lejeune, NC.



HM3 Marques J. Nettles, 22, of Beaverton, OR, died 2 April when the truck he was riding in rolled over in a flash flood near Al Asad, Iraq. Nettles was previously listed as Duty Status—Whereabout Unknown. His body was recovered 16 April. Nettles was assigned to the 1st Combat Logistics Battalion, 1st Marine Logistics Group, 1st Marine Expeditionary Force, Camp Pendleton, CA.





Flight Surgeon to the Rescue

L T/JG Dennis Earl was deployed aboard the aircraft carrier USS *Oriskany* (CVA-34) on *Yankee Station* with Air Wing 16 of VA-163 Squadron and had already flown 62 combat missions without major incident. His 63rd mission over North Vietnam almost turned out to be his last. It was 20 October 1967.

We launched off as a flight of four. Two of us, [LCDR] Jim Busey and I, were flak-suppressors for two other A-4s that were carrying Walleye air-to-surface missiles. The objective was to take out a bridge and we were to knock back the flak, if there was any. They vaporized the bridge with the first Walleye.

Then we split up and went two for two into different areas. Jim Busey and I were flying backup to check out some water-borne logistics craft (WBLCs) in the Yellow River area. These were barges camouflaged on the banks of a river. We were headed back to take those out with our weapons, and were doing some road reconnaissance en route. I was flying behind Jim, and I was weaving down a road at 3,000 feet, a little above and behind him, crossing from his left to right. I was finishing up the cross from his left to right about a mile behind him. That's the usual formation for road reconnaissance. You stay out of phase with each other and usually leave a mile separation. If the lead can then spot a target in time, such as trucks at a road intersection and describe them, the pilot following could then pop into a roll-in position and roll in on the targets.

Anyway, in the middle of doing this, I got hit by triple A [antiaircraft] fire being shot at him.

The projectile, which was a 12.7mm shell about the size of a .50 caliber, came in the lower forward nose section just above the nose wheel well. It penetrated a couple of bulkheads and split in two on the left rudder pedal. Half of it got my left foot and the other half got the tibia of my right leg. It had just enough energy to do the job because the boat tail bullet was lying on top of the boot that had split. The other half was projecting out the other side of my G-suit [pressure suit] after it had gone through my tibia.

As soon as I was hit, I jinked to make sure there wasn't anything else coming up, then checked out the airplane. I first checked the engine instruments to make sure there wasn't a compounding problem. I knew I was in some kind of trouble but wasn't sure what it was. At first I thought it might have been a surface-to-air missile because we didn't have any indications of anything happening. But I knew right away I was in quite a desperate situation and bleeding pretty well. There was a nose wheel and unsafe gear light flashing and a

couple of other annunciator lights. There was also some smoke in the cockpit, and I wasn't sure if I was going to be able to fly it out of there.

We were just south of what they called the Hour Glass River close to a karst ridge, geographically pretty close to Phu Ly, a major center for North Vietnamese transportation. North Vietnam is kind of narrow. Down in that area it was probably no more than 40 or so miles wide. We were only about a third of the way in from the coast, maybe less than that.

Fortunately, in a jet like the A-4, the rudder pedals aren't really needed in normal coordinated flight so I could use the stick for control. In most jets with swept-back wings, you don't need the rudder unless you're trying to exaggerate a turn rate.

I notified Jim Busey and told him I had taken a hit and had two broken legs. Of course, that got his attention. He told me to turn toward the coast. Your first inclination is to get away from land so you wouldn't get picked up and incarcerated. So I turned to the east and pickled off the weapons I had left. This means getting rid of ordnance. You can pickle them either deliberately over a target or just get rid of them to lighten the plane. On that



LTJG Dennis Earl's A-4 Skyhawk safely aboard *Oriskany* after the wounded pilot hit the nylon emergency barrier.

mission, I had six Mark 82s—"daisy cutters," which together weighed about 3,000 pounds.¹

It was about a 25-minute flight back. This was when Doc [LCDR Allan] Adeeb came into the picture. He was listening to the calls on the radio and suggested that I inflate my G-suit to put compression on the injury to reduce the bleeding.

The lower bladder of my G-suit was punctured, but if I held my hand on the G-suit actuator, I could actually inflate it without pulling Gs by pushing down on a plunger. That would cause a restriction in the upper bladders which weren't damaged. And this restriction reduced the blood loss. But, at that point, things were starting to clot up anyway. I also was in a lot of pain, especially in my left foot.

As for the right leg, the bullet had just about enough energy to do its job, which was to take a chunk out of the tibia about a half-inch wide. I was able to fly with my right hand and lift the weight off my right leg with my left hand. I did that for the 25 minutes it took to get back to the ship.

I never felt like I was going to pass out but the ship's crew thought I might, so they rigged the barricade

for my recovery. It was probably the best landing I ever made. I had told them I didn't need that barricade but they rigged it just in case, and I wasn't going to argue with them. The ship was still in a turn as I made my approach. I didn't do the normal 350-knot break turn and come back around and land. I just did a long left-base entry, and when the ship steadied up, I steadied up and made it straight in.

What they did in technical terms was to adjust the roll angle for the optical landing system so that instead of targeting the "Three" wire, it targeted the "One" wire. And that meant I touched down on the deck earlier and grabbed the "One" wire. But most of the energy was taken out of the landing by the time I got to the barricade.

As soon as I felt the tug on the wire, I pulled it to idle and the airplane nosed into the barricade. Then I shut the engine down. They had a forklift with a pallet and mattresses on it which they pulled alongside the cockpit. A couple of corpsmen helped me stand up on my left foot. Then they eased me into a litter after which they strapped me down and lowered the forklift.

The next thing I knew, I was in a weapons elevator going below right to sick bay. With a shot of morphine, I was starting to feel quite a bit better.

That's when I first met the doctors who were going to work on me—Dr. Gallitano and Dr. Adeeb. Shortly after I landed, Dr. Adeeb landed and the two of them went to work. I remember them cutting off my G-suit and my boots and started a drip. The next thing I knew, I woke up on a cot in sick bay with a cast up to my hip on the right leg and a half-cast up to my knee on the left leg and foot.

The round had gone through the ball joint of my big toe so I don't have a joint there anymore. The adjacent toe was fractured but the doctors didn't have to do anything beyond splinting it. The docs put two K wires through the tip of my big toe down through the ball joint into the bone extending back from the big toe. They lined up all the bones and stabilized them. They then removed some skin from my left thigh and did a skin graft over the missing skin. That's one thing that amazed the doctors when I got to Pensacola. This skillful grafting had not resulted in the kind of infection they had previously seen in patients coming back from Vietnam.

About a month and a half after I got back to Pensacola, the doctors removed those K wires. I was still in a half-cast on my left foot but I could walk around on it. They put a walking cast on it and I used crutches for my right leg. I had a cast that went past my right hip all the way down the leg, so it was held in that position until it knitted across the gap. There were no wires, screws, or anything.

I was married in February without the cast but was still on crutches. My brother carried my wife across the threshold for me.

LCDR Allan Adeeb, Oriskany's senior medical officer, was a "dual designator," one of a handful of men who wore both the medical officer's oak leaf insignia and the gold wings of a naval aviator.

When he wasn't attending patients in sick bay, Dr. Adeeb flew A-4 tanker missions. "If somebody took a hit in the wings and was losing fuel, I'd go out and find them. They'd plug in [connect to the tanker's refueling hose] and I'd take them back to the ship." Adeeb was in the air that day flying a tanker mission.

¹A 500-pound bomb

Jim Busey was nearby and I heard all this conversation about Denny Earl bleeding and that he didn't know if he was going to make it back. So I called Jim and said, "Tell him to inflate his pressure suit. That will act like a tourniquet."


Busey then radioed Earl and told him to inflate his pressure suit, which he did, and then made it back to the ship.

I landed when they were already getting him ready for surgery. Al Gallitano was the general surgeon. I came down right from the flight deck, took off my flight suit, put on my scrub suit, went in and helped operate on this guy without missing a beat. Al was such a great doc. In those days, they taught the surgeons a lot of orthopedics. We had Denny off of the ship and back to the States in about 36 hours.

LT Alphonse Gallitano had only been aboard Oriskany a few days when the badly injured LTJG Earl was brought into the carrier's operating room.

Earl had taken a large caliber round through his right lower leg, which shattered it. He nearly lost the leg, which was almost shot off. He had also lost a fair amount of blood. We controlled the bleeding, gave him blood, and repaired the broken tibia.

I hadn't seen wounds caused by high-caliber bullets before, but in Boston we had a "knife and gun club" which provided a bit of mayhem, so we got to see a fair number of those kinds of wounds. I was very well trained, having been through 5 years of surgical training in Boston and another year in Houston.

We stripped off all his clothing, debrided the dead and badly injured tissue, and irrigated the wound. We then aligned the broken fragments of bone, put him in traction, and while he was in traction, put him in a cast. It wasn't an extensive operation. I think it only took an hour or two. Dr. Adeeb assisted me. 

LCDR Earl retired in 1984 and now flies for the Navy as a contract pilot training weapons systems operators. He resides in Pensacola, FL.

Dr. Adeeb left active duty in 1969, joined the Naval Reserve, and continued to fly A-4s until he retired from the reserves in 1976. He practices anesthesiology in Jacksonville, FL.

Dr. Gallitano is retired and lives in Lincoln, MA.



Oriskany today

(Top) Guided by a flotilla of tugboats and small craft, the decommissioned carrier passes Pensacola's historic Fort Pickens on the way to its final resting place. On 17 May, the vessel was scuttled 22 miles south of Pensacola in about 212 feet of water. It is now the largest ship ever intentionally sunk as an artificial reef. Photo by Mike O'Connor

(Left) Former Gunner's Mate Mike Hajek, Jr., who served aboard from 1949 to 1954, salutes his former ship. Photo by Gary Nichols

(Right) Sailors once stationed aboard the old carrier reminisce. Photo by JO1 Jackey Bratt, USN

Mobilization

An Amazing Experience

CAPT Sherry Lee Brown, NC, USNR (Ret.)

Operation Desert Storm was both stressful and exciting for Navy Nurse Corps reservists. It was a time of testing one's flexibility but it was also a time for being concerned and sometimes frightened about the unknown.

During Desert Shield/Desert Storm huge numbers of active and reserve personnel were mobilized. Everyone had their own unique experience. My story is only one of many. For me it was a time of major adjustment and challenges, but also personal growth.

I was a clinical nurse specialist at the Salt Lake City Veterans Administration Medical Center, and also a reservist, drilling once a month and serving 2 weeks active duty a year. When Iraq invaded Kuwait in August 1990, I remember thinking the reserves were going to get involved in this conflict and that I would be mobilized. Everybody told me it wouldn't happen, but I knew it would. I also knew it would be a very difficult time for the reserves.

My mobilization billet was Naval Hospital Oakland. I knew that if the USNS *Mercy* was activated, Oakland personnel would be mobilized to backfill Oakland. I told the VA chief nurse, "If the *Mercy* gets mobilized, the Navy nurses at this hospital are out of here." I don't know if she believed me, but within seconds after the *Mercy* was mobilized, Naval Hospital Oakland and other Navy hospitals emptied out to man the ship. Reserve nurses with mobilization billets to those facilities were tasked to backfill those hospitals.

Some nurses at the VA Medical Center were immediately mobilized. We went various places. I was sent with three other nurses from my reserve unit to Lemoore Naval Air Station. The nurses were the first of many reserve nurses and physicians and support personnel from several services to leave the VA Medical Center, and this facility would lose many more over the next several months. The remaining staff worked short the whole time we were gone. Our mobilization was very hard on them as well.

We got the mobilization call the Friday before Labor Day and were to report to the reserve center on Saturday for processing and to Lemoore Naval Air Station, CA, the following Tuesday. I was the reserve unit's executive

officer and had the distinct honor of calling the members of our unit to tell them they were being mobilized. One of those nurses had just moved to Salt Lake City to begin teaching nursing at the University of Utah; the fall semester was just a few weeks away. She hadn't even started

drilling with our unit yet. I remember telling her, "You don't know me yet, but I'm your executive officer and I'm calling to tell you that you are being mobilized." Her response was one of utter shock.

At Lemoore, I was a division officer for the medical-surgical unit, a unit for all ages. I was used to caring for adults, and the first time I was asked to start an IV on a baby I thought to myself, "You've got to be kidding!"

The nurses in my division came with a variety of nursing and Navy experience. Some had not been in the reserve very long and really didn't have a clear concept of what the reserve was all about. Some were very surprised they had been mobilized. My job, as division officer, was to pull together a cohesive group of nurses to function well. It was a challenge. Some were having difficulty adjusting and understanding why they were there and how they got there. They were in shock that they were taken out of their secure and comfortable environment—work and home—and put in a strange place doing things they weren't comfortable doing. They were ill at ease finding themselves in the middle of a war with the uncertainty of



CAPT SHERRY LEE BROWN

how long they would be there. It took a while for all of us to settle into our new roles.

Mobilization was stressful for reserve nurses but it was also stressful for the active duty staff as well. We had many brand new hospital corpsmen right out of corps school. Some were also “8404s.” I remember one young corpsman on my unit who had received orders to the Gulf. He was so afraid. I knew he had to go; it was his duty. I spent a long time trying to help him understand and offered words of encouragement. But I didn’t really know how to help him because I didn’t know what he’d be facing. In my heart I was afraid for him as well. I knew he had received excellent training, but the unknown was so great.

The reservists at Lemoore initially had 90-day orders, but none of us knew whether we would be finished in 90 days, whether others would come to replace us, or whether we would be extended. It was new to all of us. The rumor mill was terrible and working overtime. This was very frustrating. We were all glued to CNN trying to figure out what was going on in the world.

There was a significant delay between the time we were mobilized and when the war actually started. One day I was meeting with the command leadership when word came that the bombing had started. I had a terrible sinking feeling. It was just such a sense of “Oh, my gosh! This is really happening.”

It was about that time, in late December and early January, that more people from Lemoore were being sent to the Gulf. There were some active duty nurses for whom mobilization would have been very difficult. I knew that decisions were being made about which nurses were going. I knew some of them personally because they were on my unit. One nurse had just returned from *Mercy*. A brand new ensign was just married. Another nurse just had a baby and was still nursing.

We had been at Lemoore since August and had been extended another 90 days by then, and were about due for another extension. There was a question whether a reservist could be mobilized to the Gulf. I told the command that if one of my nurses had to go, I would like to be the one. I saw it as another opportunity to serve our troops and thought it would be a good experience. I also knew it would be easier for me to be mobilized than some of the other nurses. Soon we received another extension on our orders for an indefinite period, which made reservists mobilizable, just like the active duty staff.

I was mobilized in late January. A physician and I flew commercially from Lemoore to Charleston, SC, where we remained in a hotel staging area waiting for further orders for about 4 days. Then word came that we were going to be shipped out. A lot of people were involved in this mobilization—a whole plane full.

We were taken by a military transport bus to an Air Force base in South Carolina, but not told where we were going. They were very secretive, and it was unnerving. Anyway, we got on the transport bus and went to this air base and sat, and sat, and sat for hours on the hard seats in the terminal. Finally, we flew to Bangor, ME, and then to Italy. There, the security was so tight they wouldn’t let us off the plane so we sat out on the tarmac in the heat for a long time.

Eventually, we took off for Saudi Arabia, where we were loaded into canvas-topped military trucks. We traveled in the night, in the pitch dark, for what seemed like hours until we arrived at Fleet Hospital 5 at Al Jubail, Saudi Arabia.

The active duty personnel had already set up the 500-bed combat zone hospital, and it had been operational for months. We got there at about one in the morning. It was dark and cold and I was very tired. Another nurse and I arrived at the same time. She had come from Camp Lejeune. We were handed a sleeping bag and a trunk and told to go to our tent, a big general purpose tent. Everyone was asleep and it was pitch dark and we had all our bags and gear. We quietly found two empty cots and crawled into our sleeping bags. I remember crawling down into that sleeping bag as far as I could because I was so cold. There was no heat in the tent, but I was so tired I just went to sleep.

The next morning the “hut mother”—every tent had an assigned “hut mother”—woke me up. I had not even heard reveille. She said to the group, “You know, there are two more people in this tent than there were when we went to sleep last night.” I crawled out and met my new “hut mates.”

There were eight cots in this tent and it was now full. I was the only reservist. I found out later that I was the only reserve nurse at the hospital. We dressed in clean uniforms, had breakfast, began our orientation, and went to work.

I worked on a medical-surgical unit, each unit having a capacity for 20 patients. The hospital was made of temper tents spread over a huge area. Temper tents are climate-controlled with air conditioning and heating. Some had solid walls, like the operating rooms. They made up a complex of units attached to a very long corridor that connected all the units.

We treated many Allied troops for assorted injuries and illnesses. Asthma was a big problem related to the dust and the terrible smoke from oil fires. We had a number of friendly fire and grenade injuries. We also saw soldiers with very serious injuries, some due to vehicle crashes. The dust storms were very bad and the poor visibility caused a number of these accidents. But all of us were

thinking and wondering about what would happen if our troops experienced a lot of casualties. We talked a lot about the worst case scenario. Would the injured be able to be transported in time? Could we handle the casualties? Could we help?

I was on duty when the ground war started a few weeks later. I was also on duty the night a scud missile hit the dormitory in Riyadh about 100 miles from us. We knew we wouldn't get any of those casualties, but we were very sad for the loss of life and injuries our troops had sustained. It was sad and sickening to hear about those casualties.

There were times I was afraid. Almost every night there would be one or two air raids. I could lie in bed and hear the bombs exploding in the distance. We had a couple of near misses with scuds. One fell not far from the hospital but it turned out to be a dud.

The ground war didn't last very long and, fortunately, the combat casualties were few. Shortly after, they began demobilizing personnel. Fleet Hospital 5 was one of the first to be shut down because it had been there since the very beginning. I was one of the first ones to be sent back. I felt bad about that because I knew so many had been there much longer than I had, but I knew the rest would be going home within a few weeks. I was done in Saudi. I knew I was going back to Lemoore but didn't know for how long.

The trip home was not as traumatic as the trip coming. It was very exciting to be getting closer to home. We went by bus from the Fleet Hospital to Al Jubail Airport, where we boarded a commercial 747 contracted to transport the troops. A big yellow ribbon was painted on the plane. It was a very emotional experience. We flew to Portsmouth, VA. Most of those on the plane had been mobilized from Portsmouth, so they were essentially taking the Portsmouth Naval Hospital people home first. It seemed that all of Portsmouth knew they were coming so there was a big celebration and people were reuniting with families and friends. It was exciting to witness these reunions.

But, I felt very alone, even though I felt supported by the community, and the country as a whole. Unlike Vietnam, the nation supported those who went away to Desert Storm so I didn't feel like I was returning to a hostile environment. We had gone through some debriefing at the Fleet Hospital trying to prepare us for the adjustment of going home. Even though I had not been in Saudi very long, I had been away for many months so I knew I would experience some readjustment.

The next day we took a military bus to the airport and flew to California. I was glad to be back at Lemoore. I checked in at the BOQ, got my old room back, and checked in for duty. I was there less than a week because

people were now being sent home. Personnel from *Mercy* were on their way back. I was put on the list to be deactivated in the first wave, so I came home to Salt Lake.

I took a few weeks off and then went back to work at the VA, which was very supportive of veterans and supportive of the military. There I assumed my previous position. I was lucky. There wasn't a question whether I would get my job back. Things slowly got back to normal for me. But my experience in Desert Storm gave me a greater appreciation for the veterans. I had always appreciated what they had done and I loved them for their sacrifice. But now I felt even closer to them. I now had something in common with them.

I had a strong faith before my Desert Storm experience, and was fortunate to be able to attend church services both at Lemoore and at the Fleet Hospital. I prayed for our soldiers and that we wouldn't have a lot of casualties and that I would be able to do what I needed to do and be able to handle whatever came. I think an experience like that makes you realize how important your faith is to you and how much of a support it is.

The Desert Shield/Desert Storm experience impacted my life and my practice after I came home. I remember thinking afterward that I could accomplish anything I set my mind to. Things I had been afraid or reluctant to do before, I now took on as opportunities. The experience of being a division officer at Lemoore made me more confident about my ability to function in a military situation. Being a direct appointment officer, I had not had much military experience prior to the mobilization, except for a prior deployment in 1987 when I had been a member of the first crew of *Mercy* during the humanitarian mission to the Philippines. That was an incredible experience, one that also impacted my life and nursing practice. In both experiences I found that I brought with me, not so much military knowledge, but a great deal of knowledge and experience from my many years as a civilian nurse, experience that enabled me to go in and do the job.

I remained in the Navy reserve for several more years after Desert Storm. I was not mobilized for Iraqi Freedom, but was prepared to go. I am very proud to have served my country and will always be grateful for the opportunities and experiences I had as a Navy nurse. ✍

CAPT Brown's oral history is part of the Nurses at War Project, an ongoing program at Brigham Young University College of Nursing. This project collects the accounts of nurses who have served during periods of armed conflict. If you are a nurse or know a nurse who has served in wartime, and would like more information on participation in this program, please contact CDR Patricia Rushton, NC, USN (Ret.), RN, Ph.D., at Patricia_Rushton@byu.edu.

Letter to the Editor

I was so very pleased to see CDR Patricia Rushton's article, "Caring The Best and Finest Part of Nursing," in *Navy Medicine* May-June 2006. It is a name I will never forget, for she was the most caring nurse that I have ever met!

CDR Rushton, was one of my nurses at the Naval Hospital Philadelphia, PA, Hand Orthopedic Unit Ward 2B, in 1971. I was an 18-year-old sailor who suffered the partial amputations of both my index and middle fingers of my dominant hand. I was taken from my ship (USS *Luce* (DLG-7), in the Philadelphia Navy Yard directly to the hospital emergency room.

After the initial evaluation visit to the orthopedic clinic, I was told by the doctor that they would try to re-attach my fingers. I was wheeled in the Ward 2B to be prepared for surgery. ENS Rushton got up from her desk and sat next to me. She could tell that I was scared and assured me everything would be fine.

After the corpsman cleaned and re-dressed my injury and had me change clothes into a gown for the surgery, I asked her if it would be all right to call my parents and inform them of my accident and pending surgery. She allowed me to do so, and even took the time to dial the number and speak with my mom, assuring her that I would receive excellent care and be all right.

After surgery, I returned to Ward 2B. When I was fully awake I saw that my left arm was being held up by what looked like ace wraps strung on the bed, and tong blades taped together to make some sort of sliding cradle. My hand was one big ball of bandage. ENS Rushton came over to me and asked me how I was doing? Did I have any pain? She checked my temperature and blood pressure. I got enough courage to ask her if they had to cut off my fingers. She told me no, that they re-attached them and told me to not worry and to rest.

The next morning when I awoke, I saw that I was not alone. The ward was a bay unit, nothing like the private or semi-private hospital rooms of today. I looked around a saw 19 or so other guys—all just kids like me. Most were Marines who were injured in Vietnam. Some were missing hands, arms, feet, legs, or a combination of both. Over the next year, I underwent more surgery on my fingers and many long weeks of occupational therapy to regain the use of my fingers and hand. I can honestly say, I never saw a bad nurse. All were very competent, but to some it was a job, and to others nursing was a passion, a love. We, the patients, could easily see that ENS Rushton had a passion for nursing. She treated us as men, but knew deep inside that we were kids, kids scared of our wounds, injuries, and the future. There were many times she did little things for us that were not done by the nurses on previous shifts, like cranking up the bed for a Marine who was trying to sit up to read, give a guy a back rub, or pull the covers up and tuck them in for a guy who just fell asleep after he received a "pain shot," or just sit next to a patient and let him talk to her like she was a big sister. ENS Rushton cared for us. Her caring rubbed off on us, too. We (without being asked) would prepare the ace wrap bed slings for our buddies who went back into surgery or for new guys on the ward. Her passion for nursing taught us to care for each other. I, for one, after returning to full duty, re-enlisted to go to Hospital Corps School and returned to Ward 2B as a corpsman a year later.

Thirty plus years have passed since I was that scared kid on Ward 2B. I have forgotten the names and the faces of most of those doctors, nurses, corpsmen, and patients. But I have not forgotten ENS Rushton. So, for all those guys on Ward 2B. Ms. Rushton, thank you for being our nurse. Thank you for caring for us. I learned from you that the most important aspect of healthcare is "the caring."

Very respectfully,
LCDR Stanley Godlewski, MSC, USN (Ret.)

The Naval Hospital Fund

Doug Flynn

With approximately 25 years of federal service, Doug Flynn has spent the last 15 years in several positions focused in direct support of active duty and retired service members and their families. He is currently Head of the Congressional/BSO Support Action Team, Bureau of Medicine and Surgery (BUMED), Washington, DC.

Mr. Flynn first became interested in the promise of “healthcare for life” as a result of many beneficiary inquiries at the time the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was metamorphosing into what we presently know as TRICARE. “It wasn’t until sometime later that I addressed this question to my father, a retired lieutenant colonel of the United States Army Corps of Engineers, who confirmed that he, too, was required to pay into a fund which guaranteed him “healthcare for life.” Armed with that bit of information, I began searching for additional documentation to support his and the claims of others that the promised ‘healthcare for life’ did, in fact, exist.

“This article represents documentation gathered from limited sources of available information. My intention was to preserve this historical perspective in its entirety and my objective was for personal research only. I impart this information strictly for its historical value and take no responsibility or position for its content.”

For 145 years every officer and enlisted man in the Navy and Marine Corps contributed 20 cents per month from his pay to support the Marine Hospital Fund. For most of that time, this fund paid for the lion’s share of the Navy Medical Department’s expenses.

In 1798 Congress considered a bill which provided for the relief of sick and disabled seamen. Similar bills had been introduced in 1793 but opponents succeeded in defeating their passage.

In these early years, several states were still thinking in terms of their pre-Revolutionary days as individual colonies, and some of them began introducing legislation for the establishment of state marine hospitals. The first marine hospital was acquired by the federal government in 1801 and, since then, all hospitals of the Marine Hospital Service (now Public Health Service) have been under federal jurisdiction.

It is evident that Congress historically intended for sick and disabled

seamen, be cared for. On 19 November 1792, the Honorable Mr. Williamson, a representative from Massachusetts, delivered a speech on the floor of the House in which he said “Wherever it is probable that sailors may be sick there I would make provisions for their support and comfort. Hospitals should be erected, or lodging hired, as the case may be, at every port of entry in the United States for sick and infirmed seamen where they may be properly attended during their indispositions. The money collected at the several ports as hospital money should be expended at such ports and no other place, under the care of such person may be designated for that purpose. Let a small deduction be made from the wages of every seaman to be paid at the several ports of entry for their use. I have mentioned a deduction from their wages because this mode of raising money would probably be more acceptable and because it is the most equitable tax that can be levied.”(1)

On 28 February 1798, Robert Livingstone of New York reported a bill for the relief of sick and disabled seamen which passed both Houses of Congress and was signed by President John Adams on 16 July 1798. This Act provided for the deduction of 20 cents per month from the wages of seamen on merchant vessels of the United States. Directors of Marine Hospitals were appointed to control the expenditures from this fund. The Secretary of the Navy was authorized to deduct 20 cents each month from the pay of every officer, seamen, and Marine. Sick and disabled sailors and Marines were to be given treatment and domiciliary care in Marine hospitals.

Both enlisted and officers were dissatisfied. In fact, few officers took advantage of hospital services, preferring instead to pay the expenses of their own necessary treatment. Enlisted men frequently deserted as soon as they were physically able to do so. Medical officers generally provided better medical services on

their own and often at their own expense, than was available at Marine hospitals. Medical officers continued to criticize Marine hospitals and made every effort to influence Congress to provide separate facilities for the Navy alone.

The first medical officer of record in the forefront of this campaign was Surgeon Edward Cutbush. In February 1810, Secretary of the Navy, Paul Hamilton, addressed a letter to the Chairman of the Naval Committee in the House of Representatives, the Honorable B. Bassett. He pointed out how and why the Marine Hospital Fund was not working as designed. The amount already deducted from pay and deposited into the U.S. Treasury was then \$55,649.29. Nevertheless, no naval officer and but a few Navy seaman had received any benefit from the fund. "In the few cases which have existed of any seamen being sent to such hospitals, experience has proven that the commanding officer of ships from which they were sent would never get returns made to them, and on an average, three to five seamen have deserted as soon as they get in a convalescent state. The propriety of having distinct establishment for the relief of sick officers, seamen and marines of the Navy is evident.

"In addition to the 20 cent per month let funds be raised from such of the following sources as may be thought most advisable or to complete the goodly work at once, let the whole of them be added to the fund.

1st. Let Congress declare by law that all the balances due to deserters from the service be forfeited and thus applied.

2nd. That the balances due to seamen dying in the service should be invested in funds, and interest thus applied until such balances shall be called for by either the wives, chil-



Naval Hospital, Washington, DC. Built 1866.

Photos from BUMED Archives

dren, or known legal representatives of the deceased.

3rd. Let the disabled person entitled to a pension make his election before going into a hospital for life or receiving the pension allowed him by law. If he preferred going into a hospital for life, which many would do, then his pension would be applied toward support of the hospital.

4th. Let the balance at this time, or the unapplied amount of the money raised by deducting 20 cents from the pay of officers and so forth of the Navy be thus applied.

5th. Let Congress add to the 20 cents, which by the act of March 1799, the Secretary of the Navy is required to deduct from the pay of Navy and Marine Corps personnel, instead of 20 cents, 50 cents might be deducted. This would in itself produce 150 percent upon the amount now deducted. This contemplated belief that the officers and enlisted men would consent to deduction of \$1.00 per month if they knew the amount would be applied exclusively to their benefit.

6th. Let the rations of seamen and marines and one of the rations of

each officer, while in the hospital, be deducted and thus applied.

7th. Let all mulcts [penalties] of pay by sentence of court-martial, and all stoppage of grog for minor offenses be thus applied.

8th. Let 10 or 15 per cent of slop clothing furnished to seamen be thus applied.¹ At this time the sailor on board ship is furnished with slop quality clothing from 25 to 33 and one third percent less than he could get it out of a slop shop, so that if 10 percent on the present price were added, the seamen would still get the slop clothing from 15 to 23 percent less than he could buy it from a civilian store. Hence he would not reasonably complain at the making of the proposed addition to the price, especially when he would reflect on that amount thus produced was intended exclusively for his benefit."⁽²⁾

The Secretary suggested that wives of seamen killed on active duty would make nurses and at-

¹Slop clothing were uniforms and other official clothing for sale. The term is derived from the old terms *sloppe* or *slype*, which meant ill-fitting or loose clothing.

tendants and do the necessary sewing washing and so forth and that their children might work in the gardens. The Secretary attempted to kill two birds with one stone by establishing at the naval hospitals schools of navigation and so forth so that the children of seamen and young men entering the service as midshipmen would be taught marine sciences.

On 16 January 1811, the Marine Hospital Fund contained \$73,288.38. Of this sum, \$55,649.29 had been accumulated from the pay of officers, Navy seamen, and Marines. Moved by the pleas of the Secretary of the Navy, Congress passed a law since known as the Naval Hospital Fund on 26 February 1811. In addition to the 20 cents per month deduction from the pay of each officer, seamen, and Marine, the fund was increased by the following methods:

The value of one ration per day allowed to each officer, seamen, and Marine during his continuance in a hospital. An act of 10 July 1832 provided that all fines imposed on officers, seamen, and Marines be credited to the Hospital Fund, and on 3 March 1909 an amendment provided for the paying of money from fines and forfeitures imposed by courts marshal be transferred to the Hospital Fund. Similar amendments provided that all forfeitures on account of desertion should be placed to the credit of the Hospital Fund. The Hospital Fund was authorized to receive private donations in the name of the United States for the relief of disabled seamen and the erection and support of naval hospitals for sick and disabled seamen.

In 1823, land was purchased in Chelsea, MA, near the Navy Yard. The following year, the Navy acquired a site near the Brooklyn Navy Yard for \$7,911.75. Yet despite all this preparation, no land acquisitions or hospital starts were made until late 1827.

One of the best known architects in the United States, Benjamin Henry Latrobe, had been engaged to build a Greenwich hospital in Washington, but it is possible the disputes between Latrobe and President Thomas Jefferson incident to the construction of the Capitol led to the abandonment of the Navy hospital plan in Washington, DC. Even so, Latrobe submitted plans in 1812 and again in 1813.

The law which established the Hospital Fund provided specifically that one of the hospitals be designated as a Naval Asylum. This asylum was to be specifically for the care of aged and decrepit seamen. The site purchased at Philadelphia, formerly known as the Pemberton estate, became the Naval Asylum.

Among several senior Navy surgeons who proposed construction of naval hospitals was Surgeon W. P. C. Barton, later to become the first Chief of the Bureau of Medicine and Surgery. "Indeed I have myself seen among a number of sick seamen with whom I was left in charge at the Navy Yard, Philadelphia, where they were necessarily huddled into a miserable house, scarcely large enough to accommodate the eighth part of their number--a spirit of impatience and even of revolt. . . So wretched was the hovel and so destitute every necessary comfort for sick persons . . . [that] every man who gathered sufficient strength and was successful in getting an opportunity to effect his escape, absconded immediately." (3)

The hospital fund continued to increase each year despite the fact that a considerable proportion of it was used at least once during the War of 1812 to pay the salaries of officers and enlisted of the Navy. By 1827 the Hospital Fund had been increased to a total of \$119,907.84. An additional sum of \$72,032.96 had been borrowed from the fund to pay

salaries in the War of 1812. A total amount due the Hospital Fund then was \$191,130.80.

During 1827 construction was actually started on Naval Hospital Portsmouth, VA, and the Naval Asylum in Philadelphia. Secretary of the Navy Samuel L. Southard reported as follows:

"The Naval Hospital Fund has an intimate connexion with the interests and feelings of officers and seamen who are under the control of this department. Humanity, justice and policy require that the deceased and wounded seamen, when brought in to port, should have a home and a means of cure provided; and the disabled and aged seaman who has worthily served his country until his strength is exhausted should have an asylum where a comfortable subsistence be found for his last days. This truth has been felt in all civilized and commercial nations. It was early felt in ours and laws were passed upon the subject; but they have thus far not accomplished their object. The direct twenty cent per month to be returned from the pay of officers, seamen and marines and that from the proceeds of hospitals and an asylum should be erected. . . . Not one cent has been paid to the fund by the nation. It has been taken out of the pay of the officers and men and belongs to them as justly and any portion of their private estates." (4)

By the end of 1829 the Hospital Fund was so depleted that the building program was suspended. During the 1830s, however, several naval hospitals were finally completed--Norfolk Naval hospital, followed by Chelsea, MA, Philadelphia Naval Asylum, Pensacola, FL, and Charleston, SC. Additional facilities of a makeshift character were provided during this period at Washington, DC, New Orleans, and two or three other ports. Most of these facilities

were provided due to the aggressiveness of several Navy surgeons.

In order to add substance to their proposals for the establishment of naval hospitals, successive Secretaries of the Navy included a proposal for the establishment of a Naval Academy in conjunction with one or more of the naval hospitals. Congress finally recognized the practicality of a Naval Academy, and in 1846 appropriated monies for repair and improvement of a site at Fort Severn in Annapolis, MD, and for instructors. Thus the creation of the Naval Academy was supported, at least in part, out of the Naval Hospital Fund.

The Naval Asylum itself was supported wholly out of the Hospital Fund until July 1858 when it was placed under the jurisdiction of the Bureau of Yards and Docks.

For almost 100 years, until about 1900, the entire expense of delivering healthcare to naval personnel was paid for from the Naval Hospital Fund. At no time prior to 1900 was more than \$50,000.00 appropriated for Medical Department expenses. These expenses, with the exception of a period of the War of 1812, included the salaries of medical officers and enlisted men. The Hospital Fund not only paid Medical Department expenses but also construction funds for new hospitals. Despite this, the fund was generally solvent.

Since 1861, the Navy increased its hospitals by the addition of Philadelphia, PA, Annapolis, MD, Washington, DC, Mare Island, CA, and Yokohama, Japan. Consequently the expenses nearly doubled while at the same time the Hospital Fund from which these expenses were paid diminished in a still larger proportion due to large expenditures in building and furnishings and partly to additional expenses of supporting a greater number of hospitals.

The first million dollar balance of the Fund was obtained in 1907 when

the sum on hand was \$1,055,176.34. It was during the early 1900s that Congress began to supplement the Hospital Fund by making additional appropriations for specific construction purposes.

In summary, the origin of the Naval Hospital Fund goes back to 1798 when Congress passed an act providing for the relief of sick and disabled seamen through a tax of 20 cents per month that authorized the President to purchase land and erect hospitals from the funds collected. The act originally referred to as the Marine Hospital Fund continued until 26 February 1811, when Congress established a separate "Naval Hospital Fund." Accordingly, deductions were for members of the Navy and Marine Corps. It appears the Army had a similar program.

In 1943, the Navy recommended the enactment of proposed legislation to simplify accounting procedures within the Navy by abolishing certain trust funds, one being the Naval Hospital Fund. The fund was abolished by Public Law, 73-78th Congress for the purposes of simplifying methods of accounting and saving significantly in time and money. It was during these hearings that the bill was amended to strike out all

provisions for deducting the 20 cents per month.


There are many thoughts and opinions on the part of Navy and Marine Corps personnel who contributed monthly to the fund. It was their understanding that their contributions bestowed a greater degree of entitlement to care in naval hospitals than reflected in the "Space Available" concept now encompassed by Chapter 55, Section 1074, Title 10, United States Code. However, in 1962, the Assistant Judge Advocate General of the Navy determined that contributions to the Naval Hospital Fund do not afford a member greater entitlement to care in naval hospitals.

References:

1. Holcomb, 108.
2. Ibid., 116.
3. Ibid., 120.
4. Ibid., 125

Bibliography:

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Naval Hospital Chelsea, MA, c. 1836

In Memoriam

RADM Edward Jerome Rupnik, MC, died on 22 April 2006 in Marietta, GA, from the lingering effects of a stroke he suffered in 1986. He was 82.

The Library, PA, born Rupnik, a product of humble origins, enlisted in the Naval Reserve as a seamen recruit on 10 July 1943. Following graduation from Hospital Corps School, Great Lakes, IL, he served at Naval Hospital Great Lakes (1943 to 1944) and Naval Hospital Philadelphia (1944 to 1945).

Through the V-12 program, Edward Rupnik studied at the University of Pittsburgh, where he received a Bachelor of Science in chemistry in 1944. After the war, while on inactive service, Dr. Rupnik continued his studies at the University of Pittsburgh School of Medicine, graduating with an MD degree in 1948.

Dr. Rupnik returned to naval service in 1948 and served for the next 28 years, achieving the rank of rear admiral in 1973.

In 1950, Dr. Rupnik served as medical officer aboard USS *Lindenwald* (LSD-6), and in July of that year served aboard the transport *Henrico* (APA-45) when that vessel landed the 5th Marines at Pusan, Korea. He subsequently participated in the landings in Inchon and Wonson. And from November 1950 to August 1951, Dr. Rupnik served as the medical officer for the Commander LST Division 846 and 34.

His other duties included senior medical officer with the Joint Military Air Group, Greece; Chief of Dependent Surgery at Naval Hospital Bethesda, MD; Chief of Surgery at Naval Hospital Quantico, VA; Assistant Clinical Professor of Surgery at Georgetown University, Washington, DC; Chief of Surgery at Naval Hospital Portsmouth, VA; Head of Training and Clinical Service Branch, Bureau of Medicine and Surgery, Washington, DC; Commanding Officer of the Naval Medical School, Washington, DC; and Assistant Chief, Planning and Logistics, Bureau of Medicine and Surgery, Washington, DC.

Following his retirement in 1977, Dr. Rupnik moved to Sarasota, FL, where he obtained a private medical license, and became a member of the Florida Medical Board. Much of his free time was spent chartering his 42-foot yacht *Jolly Tar* in the Gulf of Mexico.

His career path was strewn with many awards and honors including, the Navy Commendation Medal with Gold Star, the Navy Unit Commendation Ribbon, Campaign Medal, World War II Victory Medal, National Defense Service Medal with Bronze Star, Korean Service Medal, United Nations Service Medal, and the Korean Presidential Unit Citation Badge.

Dr. Rupnik was a Diplomate, American Board of Surgeons; Fellow, American College of Surgeons, and a member of the American Medical Association. In 1969, he was awarded the American Medical Association's Physician Recognition Award.

Friends and colleagues remember Dr. Rupnik not only as a unique surgeon and clinician, but also a creative teacher, innovative organizer, and an efficient administrator.

His remains will be scattered on his beloved Gulf of Mexico in a ceremony at the end of June. ⚓



RADM E.J. Rupnik inspects personnel at Naval Medical School, Bethesda, MD, 1973.

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Navy Medicine 1943



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PhM3c Phyllis Van Pelt wheels a patient on one of Naval Hospital Brooklyn's outdoor balconies.

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